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ABSTRACT

Part of a health occupations program, this instructional unit contains 13 learning modules for use in training nursing assistants. Covered in the modules are (1) making beds, bathing patients, and measuring intake and output; (2) body mechanics, moving and lifting patients, range of motion exercises, and caring for patients in casts or traction; (3) back rubs, hair and nail care, prevention and care of decubitis ulcers, applying heat and cold, and preparing patients for sleep and rest; (4) meal preparation and serving, enemas, rectal tube insertion, fecal impaction, collecting stool specimens, gastrointestinal intubation, and colostomy care; (5) intravenous therapy and observation for transfusion reaction; (6) oxygen therapy and sputum specimen collections; (7) Foley catheters, bladder irrigation, urine straining, specific gravity of urine measurement, collecting urine specimens, and urethal catheterization and closed drainage; (8) the endocrine system; (9) the reproductive system; (10) levels of consciousness; (11) pre- and postoperative nursing care, care of dressings, and using binders and bandages; (12) caring for dying patients; and (13) admission, discharge, and transfer. Each module contains a rationale, performance objectives, learning activities and answers, terminology, and a posttest. (MN)

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HEALTH OCCUPATIONS CURRICULUM

SKILLS FOR NURSING ASSISTANT

VOLUME 3 UNIT 8

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DESCRIPTION OF UNITS

Units 1 through 7 comprise the core curriculum which is the basic curriculum for all health workers.

Those students who wish to enter the health field as nursing assistants must also complete Unit 8.

Students who wish to obtain their Practical Nurse Certificate must complete Units 1-8 and Units 14-20.

Units 9 through 13 are currently in the planning stages of development.

The following is a brief description of each unit in the HOP program.

Unit 1 introduces the health care facility, the long-term care setting, and the members of the health care teams.

Unit 2 introduces different ways to communicate feelings and ideas, and how to understand what other people try to express. In addition, human behavior and ethical and legal behavior are discussed.

Unit 3 introduces the hospital and the patient environment. It provides the information for emergency and first aid skills necessary to maintain patient safety and comfort.

Unit 4 presents anatomy and physiology as they apply to the health care workers. The organization of the human body, its systems, structures and functions are emphasized.

Unit 5 examines the body's need for food, the food's affect on the body, the five food groups, the six nutrients, and some therapeutic diets.

Unit 6 emphasizes the importance of cleanliness. Specific methods are studied to preserve medical and surgical asepsis. Bacterial names, diseases they cause, and the means by which bacteria are transmitted are examined.

Unit 7 stresses the origin, development, and use of medical terminology. Included are professional words, phrases, abbreviations, symbols, and surgical and diagnostic terms.

Unit 8 offers the opportunity to apply the basic knowledge, skills, and responsibilities needed for patient care and comfort. Skills such as bathing the patient, observations of vital signs, and the use and care of the various medical equipment and supplies are demonstrated. Performance is observed and evaluated in the lab and the clinical area.

Units 9-13 are in planning stages of development.

Unit 14 provides the practical nurse with a foundation in pediatric nursing. The growth and developmental levels of children are covered as well as diseases and conditions specific to children. Principals from previous health care units are reviewed and correlated with theory in this unit.

Unit 15 emphasizes communication skills and observations through the use of group discussion, role-playing, and audiovisual aids. Concepts of mental health as related to the practical nurse are presented.

Unit 16 studies legal responsibilities of the practical nurse. Also community resources are visited and studied and the needs of the elderly are included with clinical experience in a long term care facility.

Unit 17 studies the common medical and surgical conditions and the clinical practice of nursing care for these patients. The principles of adapting basic nursing care and related procedures to the individual patient are practiced.

Unit 18 stresses the prevention, promotion, and maintenance of health during the prenatal, anti-partal, and the neonatal period, including the complications that are related to obstetrical nursing.

Unit 19 covers the elementary principles involved in the administration of medications and in weights and measures. The medications commonly used in the treatment of disease are discussed in terms of actions, side effects, and dosages.

Unit 20 emphasizes proficiency in the application of knowledge and skills learned throughout the training program while in the role of a practical nurse in a clinical setting. Nursing history and organizations are also explored.

REFERENCES AND REQUIRED TEXTS

The following is a list of required textbooks and reference materials.

REFERENCE BOOKS

1. Hospital Research and Educational Trust (HRET), Being a Nursing Aide, Robert J. Brady Company, Bowie, Maryland, 1978.
2. Anthony, Catherine Parker, Structure and Function of the Body, C.V. Mosby Company, St. Louis, Missouri, 1980.
3. Velma L. Kerschner, R.N., B.S., Nutrition and Diet Therapy for Practical Nurses, F.A. Davis Co., Philadelphia, Pennsylvania, 1977.
4. Thomas, Clayton L., Taber's Cyclopedic Medical Dictionary, F.A. Davis Company, Philadelphia, Pennsylvania, 1979.
5. Staton, Thomas F., How To Study, Montgomery, Alabama, 1968.
6. Mosby's Review of Practical Nursing, C.V. Mosby Company, St. Louis, MO., 1970.
7. Tucson Community Council, The United Way Directory of Social Resources, Tucson, Arizona, 1978.

REQUIRED BOOKS

1. Marlow, Dorothy, RN Ed. D., Textbook of Pediatric Nursing, W.B. Saunders Co. 1977.
2. Caldwell, Esther, and Barbara R. Hegner, Geriatric Nursing, A Study of Maturity, Delmar Publishers, Albany, New York, 1976.
3. Johnston, Dorothy F., Total Patient Care, The C.V. Mosby Company, St. Louis, Missouri, 1979.
4. Bethea, Doris C., Introductory Maternity Nursing, J.B. Lippincott Co., Philadelphia, Pennsylvania, 1976.
5. Falconer, Patterson, Gustafson, Sheridan, Current Drug Handbook, 1980-1982, W.B. Saunders Co., Philadelphia, Pennsylvania.
6. Morgan Arthur James, M.D. and Mabye K. Johnston, R.N., Mental Health and Mental Illness, J.B. Lippincott Co., Philadephia, Pennsylvania, 1976.

DEFINITIONS AND EXPLANATION OF CURRICULUM COMPONENTS

To assist you in understanding how to use these units, we have written the following definitions and explanation for the terms which will be encountered.

Unit: One whole book or topic. Each unit has a number and a title. This first unit is Unit 1; its title is: The Health Care Facility and the Health Team.

Module: Each module has a letter and a title and is like a chapter in a book. The first module in Unit 1 is: Module A, The Health Care Facility.

Suggested References: These are included in the front of each unit only to be utilized if the student is interested in learning more about a subject or trying to understand something more thoroughly.

Rationale: A statement which tells why it is important that the student learn the material contained in each unit.

Performance Objective: Found at the beginning of each module, this tells the student specifically what he/she needs to identify, describe, or demonstrate after completing each module. The student will show the instructor through either written evaluation or by demonstration that he/she has learned what is stated in each objective.

Learning Activities: Found at the beginning of each module, this section gives the student general information and directions on what will be needed to complete the module. Many modules are self-contained or do not require any outside resources, while others will refer the student to textbooks and/or audiovisual materials.

Activities: Information the student must learn in order to satisfactorily complete the performance objectives. Each new subject area is a different activity. Within each activity specific instructions will be given on what to read or which audiovisual should be viewed. There are also written exercises to help the student learn the material. Some of the written exercises will refer the student to the answers on the following page or the answers will be found upside down on the same page. In other exercises, the student will be asked to find the answers in the information already read.

Terminology Section: Common terms found in each unit. This section is a terminology resource for the student.

Post Test: Found at the end of each unit, this is either a written evaluation or a demonstration for your instructor which will measure your knowledge of the skill(s) covered. Your instructor will tell you when it is time to take a Post Test.

Answers to Post Test: These are the answer keys to the Post Tests.

PREFACE

To Instructors:

While preparing this curriculum for publication, the staff revised and updated previous materials. The evaluation questions have now been field tested for validity and reliability and we have established 70% as a minimum passing grade; however, we did not attach this percentage to each objective. Instead, we have introduced each objective with the phrase "To The Instructor's Satisfaction" since we believe our program is based on the individual's abilities and needs, and each instructor should assess and evaluate each student individually. We suggest that each nursing program determine the type of the evaluation and/or the minimum level for passing for their own program. Please keep in mind that our experience has shown that 70% is the minimum necessary to function safely at the bedside.

The units and the tests have been prepared by individual instructors in their own area of expertise. You will find various writing styles throughout the curriculum; however, the format for all the units is the same. The staff attempted to make each unit self-contained, but in many units this was impossible. The required texts for the program are listed in the introduction. The audiovisual materials which are required are listed within the content of each unit. If it is impossible to have these specific audiovisual materials or other required materials available in your training facility, the units can be adapted to similar audiovisuals or to instructor demonstration. The worksheets covering material on the audiovisuals can be used as study guides since the answers are included.

The tests for each unit have been written to test as many important points as possible as stated in the objectives. Although we would hope the students would learn as much as possible of the information presented, due to the overwhelming number of questions which would need to be asked, we only test over what we felt were the most important. As an instructor, you may choose to add or delete information important for your program.

In most cases, the order of presentation of the units can be determined by each program; however, Unit 4 (Anatomy and Physiology) and Unit 8 (Nursing Skills) were written to be presented together. The staff felt that the knowledge of basic anatomy and physiology applied to procedures and to skills gave a greater understanding of why the student needed to learn the material.

It should also be noted that Units 9 through 13 are not included in this published curriculum. At this writing, we have only revised and updated the materials which apply to nurse assistant and practical nurse.

NOTE:

Challenging: A statement on the first page that states, "if you wish to challenge a test, see your instructor". Some students will have had previous nursing experience or possibly had college courses covering parts of the curriculum. If the student feels he/she knows the material and can successfully complete the objectives stated in a module without completing all the learning activities, the student should ask the instructor about challenging. If he/she is successful and passes this evaluation to the instructor's satisfaction, the student may progress to the next module.

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The staff of the Pima Community College Skill Center who participated in preparing the curriculum for publication includes:

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Catherine Kelly

Typists included: Virginia Wortman
Roseann Rodriguez

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Carol Erickson, director of the Health Occupations Program at the Maricopa County Skill Center should also receive a special thanks for providing excellent technical assistance in editing and updating the current curriculum. Carol wrote the module on Long-Term Care Facilities, which is an addition to the curriculum.

Unit 8 offers the opportunity to apply the basic knowledge, skills, and responsibilities needed for patient care and comfort. Skills such as cleanliness, observations of vital signs, and the use and care of the various medical equipment and supplies are demonstrated. Performance is observed and evaluated in the lab and clinic.

NURSING ASSISTANT SKILLS

Module A1 - Make a Bed
A2 - Bathe the Patient
A3 - Take Vital Signs
A4 - Measure Intake and Output
Module B1 - Body Mechanics
B2 - Correct Procedure to Move and Lift the Patient
B3 - Various Positions for the Bedridden Patient
B4 - Range of Motion Exercises
B5 - Care of the Patient in a Cast or in Traction
Module C1 - Back Rub
C2 - Hair Care—Shampoo, Shave, Fingernail and Toenail Care
C3 - Prevention and Care of Decubitus Ulcers
C4 - Application of Heat and Cold
C5 - Preparation for Sleep and Rest
Module D1 - Meal Preparation and Serving
D2 - Enema Procedure
D3 - Rectal Tube Insertion
D4 - Fecal Impaction
D5 - Collection of Stool Specimens
D6 - Gastrointestinal Intubation
D7 - Colostomy Care
Module E1 - Intravenous Therapy
E2 - Observation for Transfusion Reaction
Module F1 - Oxygen Therapy
F2 - Sputum Specimen Collections
Module G1 - Foley Catheter
G2 - Bladder Irrigations
G3 - Urine Straining
G4 - Specific Gravity of Urine Measurement
G5 - Urine Test for Blood
G6 - Collection of Urine Specimens
G7 - Urethral Catheterization and Closed Drainage
Module H - Endocrine System: Test Urine for Sugar and Acetone
Module I - Reproductive System: Use of the Vaginal Douche for Female Hygiene
Module J1 - Levels of Consciousness
J2 - Neurological Signs
J3 - Seizure Precautions
J4 - Protective Restraints
Module K1 - Preoperative Nursing Care
K2 - Postoperative Nursing Care
K3 - Care of Dressings

Module K (continued)
    K4 - Use of Binders and Bandages
    K5 - Care of the Patient with Tubes Connected to Gravity or Suction
    K6 - Cultural Awareness for Preoperative and Postoperative Care
Module L - Care of the Dying Patient
Module M1 - Admission
    M2 - Discharge
    M3 - Transfer
Terminology
Post Tests:
1. Module A
2. Module B
3. Module C
4. Module D
5. Modules E and F
6. Module G
7. Modules H and I
8. Module J
9. Module K
10. Module L
11. Module M

Answer Sheets

When you have completed the Learning Activities and are ready for a test, or wish to challenge a test, please see your instructor.

Suggested References

1. Being a Nursing Aide, Hospital Research and Education Trust, Illinois, 1969.

2. J. B. Lippincott Co., East Washington Square, Philadelphia, Pennsylvania 19105. (audiovisual)

    Making an Unoccupied Bed
    Bed Bath
    Care of Dentures

3. Trainex Corporation, P. O. Box 116, Garden Grove, California 92642. (audiovisual)

    Temperature, Pulse, Respirations
    Blood Pressure
    Moving and Lifting the Patient
    Positioning to Prevent Contractures
    Range of Motion Joint Exercises
    Care of the Patient in a Cast
    Introduction to Traction
    Local Application of Heat and Cold
    Feeding the Patient
    Cleansing Enemas
    Oxygen Administration
    Urinary Care
    Nursing Care During Intravenous Therapy
    Male and Female Catheterization
    The Use of Protective Restraints
    Preoperative and Postoperative Care
    Application of Binders and Bandages
    Care of the Dying Patient

NURSING ASSISTANT SKILLS

Module A1 - Make a Bed

RATIONALE

In your work as a nursing assistant you will be making many beds. Some beds will have patients in them; others will be empty. When a person becomes a patient, he/she will spend more time in bed than normally accustomed. The way the patient's bed is made is very important. Health care facility beds are made much more carefully than is necessary at home.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction you will:

1. Demonstrate making:
    a. A closed bed
    b. An open bed
    c. An occupied bed
    d. A postoperative bed

LEARNING ACTIVITIES

Directions: This is the first of four parts in Module A. All of the information you will need to complete this part of Module A is included here and in the filmloop. You will be asked to demonstrate the procedure for making four types of beds. The part of the procedure labeled DEMONSTRATION/COMMENTS is for your instructor to use to make comments while you demonstrate the steps of each procedure. The comments made are to help you and to let you know how well you did during your demonstration. If you have any questions at any time, STOP, and ask your instructor for help.

ACTIVITY #1. Making a Bed

Directions: Before addressing the specific objectives, read the following general information on making a bed.

1. The most important principle is to keep all sheets tight and free of wrinkles. Wrinkles are not only uncomfortable to the patient but also cause painful bedsores. The patient's blood supply is cut off by the pressure of the weight of the body against a wrinkle in the sheet. A reddened area forms first, then a blister which opens into a sore as the pressure continues. If the patient's bed is not made smooth and free of wrinkles, you might create a situation that will make the patient get worse, rather than get well.

LEARNING ACTIVITIES - continued

2. The bed should always be made with clean linen.

3. Avoid the unnecessary shaking or waving of the soiled linen. Such activity permits any bacteria on the linen to be thrown into the air and increases the possibility of you breathing these bacteria into your body and of spreading infection to others.

4. The health care facility floor is not clean. It is not free from bacteria. If any linen falls on the floor, discard it in the linen hamper. Do not use it on the patient's bed.

These are four basic ways to make a health care facility bed:

1. The closed bed: The closed bed is made following the discharge of a patient. The bed is made with all linens pulled up so that it will stay clean until a new patient has been assigned to it.

2. The open bed: When a new patient is admitted to the unit, the closed bed is made into an open bed by adjusting the top linens.

3. The occupied bed: If a patient is on bedrest, the bed must be made while the patient is in it. This is called making an "occupied" bed.

4. The postoperative bed: A post-op bed is made for the patient who is returning to the unit after an operation. The bed is specially made so that the patient may be transferred to it quickly and safely without loss of time or motion.

NOTE: 1. Always tell the patient what you are going to do before you do it.

2. Always maintain the patient's privacy.

Exercise

Directions: View the filmloop, Making an Unoccupied Bed by J. B. Lippincott. After you have viewed this filmloop, ask your instructor to demonstrate the four basic ways of making a hospital bed.

Watch a demonstration on making the:

Closed bed
Open bed
Occupied bed
Postoperative bed

LEARNING ACTIVITIES - continued

Procedure for Making a Closed Bed

Directions: Read the following procedures on bedmaking. Your instructor will check off the steps of each procedure as you accomplish them.

*PROCEDURE: MAKING A CLOSED BED	DEMONSTRATION/COMMENTS
1. Wash your hands. Select the proper linens and place them on the chair in the order in which they will be put on the bed: mattress pad, one large sheet, rubber drawsheet, a drawsheet, third large sheet, bedspread, pillowcase, pillow. ✓	1. ____________________
2. Adjust the bed to a comfortable working position for you.	2. ____________________
3. Place the mattress pad on the bed. Place the bottom sheet on the bed with the centerfold in the center of the bed. Unfold the sheet and place the bottom hem even with the foot of the mattress.	3. ____________________
4. Lift the head of the mattress with your nearest hand and tuck 15-18 inches of the sheet under the mattress with your other hand. Make a mitered corner as demonstrated in the filmloop.	4. ____________________
5. Tuck in the sheet on the side of the bed.	5. ____________________
6. Place rubber drawsheet on bed about two feet from the head of the bed.	6. ____________________
7. Place drawsheet over rubber drawsheet and tuck sides under the mattress.	7. ____________________
8. Place top sheet and bedspread on the bed with centerfold in the center of the bed and tuck under the foot of the mattress and miter the corner.	8. ____________________

*This procedure may vary from facility to facility. Ask your instructor what procedures and linens are used in the facility where you are working.

LEARNING ACTIVITIES - continued

PROCEDURE: MAKING A CLOSED BED		DEMONSTRATION/COMMENTS
9.	Make the other side of the bed in the same manner. Pull the sheets tight before tucking.	9. ________________
10.	Pull top sheet and spread to top edge of the mattress and make a cuff.	10. ________________
11.	Put the pillowcase on the pillow and place the pillow at the head of the bed. Open end away from the door.	11. ________________

Procedure for Making an Open Bed

PROCEDURE: MAKING AN OPEN BED		DEMONSTRATION/COMMENTS
1.	Make a closed bed.	1. ________________
2.	Pull the top sheet and spread down to the foot of the bed until you have uncovered at least half of the bed.	2. ________________
3.	Fold the top bedding back on itself toward the top of the bed.	3. ________________

Procedure for Making an Occupied Bed

PROCEDURE: MAKING AN OCCUPIED BED		DEMONSTRATION/COMMENTS
1.	Wash your hands. Select the proper linens and place them on the bedside chair in the order in which they will be put on the bed.	1. ________________
2.	Screen the patient and explain what you are going to do. DO NOT EXPOSE THE PATIENT.	2. ________________
3.	Adjust the bed to a comfortable working position for you.	3. ________________

LEARNING ACTIVITIES - continued

PROCEDURE: MAKING AN OCCUPIED BED	DEMONSTRATION/COMMENTS
4. Raise the side rails on one side of the bed. Have the patient turn to that side of the bed. The patient's back will be towards you.	4. ____________________
5. Pull the dirty bottom sheet and drawsheet from under the mattress and fanfold it close to the patient's back.	5. ____________________
6. Place the bottom sheet on the bed with the centerfold in the center of the bed and the bottom hem even with the foot of the bed. Tuck the top of the sheet and miter the corner. Tuck the side of the sheet. The other side is placed close to the patient's back.	6. ____________________
7. Place the rubber drawsheet and drawsheet on the bed. Tuck one side close against the patient's back. Tuck the other side under the mattress.	7. ____________________
8. Raise the side rail and have the patient turn over the "hump" onto the clean sheets.	8. ____________________
9. Remove the dirty linen and place in the laundry bag. DO NOT PUT ON THE FLOOR!! Pull the bottom sheet and drawsheet tightly and tuck in.	9. ____________________
10. Turn the patient on his back. Place the top sheet and the bedspread over the patient. Tuck the bottom edge and miter the corner. Loosen the top sheet over the patient's feet.	10. ____________________
11. Change the pillowcase. Place the pillow under the patient's head.	11. ____________________

LEARNING ACTIVITIES - concluded

Procedure for Making the Postoperative Bed

Directions: The procedure for making the post-op bed changes slightly from facility to facility. Ask your instructor what procedures and linens are used in each of the different facilities where you are working.

PROCEDURE: MAKING THE POSTOPERATIVE BED	DEMONSTRATION/ COMMENTS
1. Wash your hands and select the proper linens: mattress pad, one large sheet, a drawsheet, cotton bath blanket, third large sheet, bedspread, pillowcase.	1. ____________________
2. Make the bottom part of the bed as you would for making a closed bed.	2. ____________________
3. Spread the bath blanket, then the top sheet and bedspread over the bed as you would for making a closed bed but do not tuck them in at the foot of the bed.	3. ____________________
4. Fold all of the top bedding at the foot of the bed back on the bed so the folded edge is even with the foot of the mattress.	4. ____________________
5. Fold all of the top bedding at the head of the bed back on the bed until the edge meets the other edge.	5. ____________________
6. Fanfold all of the top bedding to one side of the bed.	6. ____________________
7. Put the pillowcase on the pillow and place at the head of the bed or on the chair.	7. ____________________
8. Put an IV pole in place at the head of the bed.	8. ____________________

Exercise. Demonstrate the Four (4) Basic Ways of Making a Bed

Directions: Practice bedmaking until you are able to make the bed tight and wrinklefree in no more than five minutes. Take your module to your instructor so he may write comments while you demonstrate making: a closed bed, an open bed, and a postoperative bed.

Now, ask a student to act as your patient and demonstrate making an occupied bed while your instructor observes you.

NURSING ASSISTANT SKILLS

Module A2 - Bathe the Patient

unit 8

RATIONALE

How often do you take a bath? Would it upset you if you were suddenly unable to bathe at all? All patients are concerned about bathing and need your help in meeting their needs to be clean.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction you will:

1. Demonstrate and answer written questions relating to the procedure for:
    a. A complete bath
    b. A partial bath
    c. A towel bath
    d. A tub bath or shower
    e. Perineal care
    f. Mouth care
2. Select the appropriate type of bath you would give your patient in given situations.
3. Identify the appropriate nursing action you would take in given situations.
4. Make nursing observations concerning your patient's physical condition and any emotional changes while giving a bath in the clinical area.

LEARNING ACTIVITIES

Directions: This part of Module A is long but very important. Read all of the information carefully. You will watch some demonstrations and you will be asked to demonstrate some procedures. Your instructor will make comments in your module while you demonstrate the procedures to help you to know how well you did. Remember, if you have any questions, get help from your instructor.

LEARNING ACTIVITIES - continued

ACTIVITY #1. Bathing the Patient

Directions: Read all of the following information.

A daily bath will help your patient recover from her illness. Think about what happens during a bath. The skin is lathered with soap and water, rinsed, and dried. This process removes dirt and bacteria from the skin. Bacteria cause odors. So by removing the bacteria, some odors will be eliminated. During washing, the rubbing of the skin stimulates the circulation and the blood supply to the skin is increased. This helps to prevent bedsores. In order to reach and to wash all parts of the body, the patient's body, arms, and legs must be moved. Moving the arms and the legs also helps to prevent the stiffening of the joints.

The purposes for giving the patient a bath are:

1. To reduce bacteria on the body
2. To stimulate circulation of the blood to the skin
3. To maintain normal body movements

There are four types of baths.

1. Complete bed bath: A complete bed bath is given to the patient who has just had surgery or who is too weak or too sick to help himself. Also, the patient with an IV or with injured arms or hands may be unable to use his hands to bathe and will need complete assistance. You may get little or no assistance from the patient.

2. Partial bed bath: A patient may be well enough to take care of his own bathing needs but not be well enough to take a tub bath or shower. In this case, you bathe only the areas that are hard for him to reach such as the back, legs, or feet. Set the patient up to do his own bath at the bedside — NOT in the bathroom. The bathroom is the most dangerous area in the health care facility.

   A patient may also be so seriously ill that the activity involved in giving him a complete bath might worsen his condition. In this case, you bathe those parts of the patient's body that will have an unfavorable effect on the illness or will increase his discomfort if they are not bathed. Those body parts are: the mouth, the eyes and the face, the hands, the underarms, the genitalia area, and the back. This bath is also called a partial bath. After the partial bath has been completed, massage the patient's back.

3. Towel bath: The towel bath is a special bath using a large bath towel and a solution such as Septi-soft instead of soap. The Septi-soft is a solution that is very good for dry skin. The towel bath is designed to give the patient a complete bath in a much shorter time that a regular complete bath requires. This procedure is not used in all health care facilities. Ask your instructor to demonstrate this procedure if used in your facility.

LEARNING ACTIVITIES - continued

4. Tub bath or shower: A tub or shower may be permitted by the doctor for the convalescent patient — the patient who is recovering from his illness and who has been judged by the doctor to be strong enough to get out of the bed and walk around. Elderly patients and patients who have been very ill and in bed for a long time may still be weak. You must go with this patient to the tub or shower and assist him as much as necessary, especially if this is his first time out of bed. Also, warm water may weaken a patient. You will need to assist him back to bed.

Exercise 1.

Directions: Answer these questions. The answers can be found in the preceding information.

1. List three purposes for giving the patient a bath.

   a. ______________________________

   b. ______________________________

   c. ______________________________

2. You have a patient who had surgery yesterday morning. He has a dressing, a tube in his nose which is connected to a suction machine, and an IV in his left hand. What type of bath would you give this patient? ______________

3. You have a patient with a bad heart and fluid in the lungs. He can barely open his eyes when you talk to him. Every time he is moved in bed, he becomes short of breath. What kind of bath would you expect your team leader to ask you to give this patient? ______________________________

4. List the six areas of the body you would be careful to wash when giving a partial bath.

   a. ______________ d. ______________

   b. ______________ e. ______________

   c. ______________ f. ______________

5. You have a patient who had surgery three days ago. She has a Foley catheter draining her urine, and a dressing. She is being encouraged to get out of bed frequently and is doing very well when she gets up. You will assist this patient with a ______________ bath.

LEARNING ACTIVITIES - continued

Exercise 2. Giving a Bed Bath

Directions: View the filmloop, Bed Bath by J. B. Lippincott.

Exercise 3. Giving a Complete Bath

Directions: Watch a demonstration in giving a complete bath.

Procedure for Giving a Complete Bed Bath

Directions: Read the following procedure. After you have read the procedure, practice giving a complete bed bath. Then demonstrate the procedure to your instructor. Your instructor will check off the steps as you accomplish them.

PROCEDURE: GIVING A COMPLETE BED BATH	DEMONSTRATION/COMMENTS
1. Wash your hands and collect the following equipment: bed linen, bath blanket, laundry bag, bath basin with warm water, soap and soap dish, washcloth, bath towel, gown, and lotion.	1. ______________
2. Tell your patient what you are going to do. Screen the patient and offer the bedpan or urinal.	2. ______________
3. Place the linen on the bedside chair in the order of use: bath blanket, washcloth, bath towel, gown, and bed linen.	3. ______________
4. Lower the head of the bed and the side rail on the side where you will be working. Raise the bed to a comfortable working position.	4. ______________
5. Place the bath blanket over the patient and remove the top bed linen. Remove the patient's gown being very careful not to expose the patient. Place all dirty linen in the laundry bag or a dirty pillowcase. NOT ON THE FLOOR!! Then take to the dirty linen room.	5. ______________
6. Bathe the patient. Remember to change the bath water before washing the patient's back.	6. ______________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A COMPLETE BED BATH	DEMONSTRATION/COMMENTS
7. If your patient is able, instruct him to complete his bath by washing the perineal area (vaginal area in a female—penis and scrotum in a male). Put equipment within easy reach and leave the room for a few minutes.	7. ________________
8. Rub patient's back with lotion.	8. ________________
9. Put clean gown on your patient and make the bed.	9. ________________

Exercise 4.

Directions: Answer these questions. The answers can be found in the preceding procedure.

1. When giving a bed bath, you need to first assemble the necessary equipment. List ten items needed for the bed bath.

   a. ________________
   b. ________________
   c. ________________
   d. ________________
   e. ________________
   f. ________________
   g. ________________
   h. ________________
   i. ________________
   j. ________________

2. Make a list of the bed and bath linens as you would assemble them and place them on the chair. List the linens from top to bottom in order of their use.

   a. ________________
   b. ________________
   c. ________________
   d. ________________
   e. ________________
   f. ________________
   g. ________________
   h. ________________
   i. ________________
   j. ________________

3. Where do you take the dirty linens? ________________

4. When do you change the bath water? ________________

LEARNING ACTIVITIES - continued

ACTIVITY #2. Perineal Care

Directions: Read the following information.

The perineum is the area including the penis, scrotum, and up to the anus in a male; and the vaginal area up to the anus in a female. Perineal care is the cleansing of the perineum. Cleansing is done:

1. to prevent infection

2. to promote healing

3. to minimize odors

4. to promote comfort of the patient

Most patients are able to do their own perineal care. If not, "finishing the bath", is a very important nursing responsibility.

Unfortunately, perineal care is an aspect of daily patient care that is often neglected. The first sign of poor perineal care is an odor noticeable when the patient's bedcovers are lifted. Many patients feel very uncomfortable about odor. Further signs of neglect might be a discharge or skin breakdown. Nursing prevention is essential. Poor perineal care has also been blamed for the high incidence of bladder infection in patients with Foley catheters draining the bladder. Patients with Foley catheters need even more frequent perineal care than patients without them.

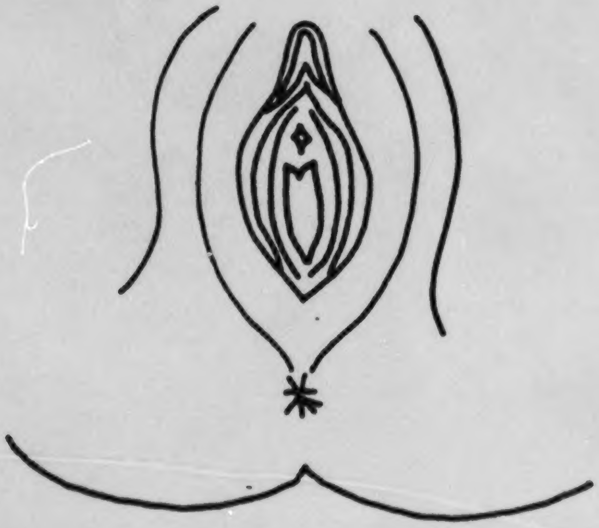
Procedure for Giving Perineal Care to the Female Patient

Directions: Read the following procedures. Then demonstrate each procedure for your instructor who will check off the steps as you accomplish them.

PROCEDURE: GIVING PERINEAL CARE TO THE FEMALE PATIENT	DEMONSTRATION/COMMENTS
1. Wash your hands and collect the following equipment: a clean measuring container filled with warm water, soap, bedpan, washcloth, and hand towel.	1. ____________________
2. If your patient is unable to finish her own bath, explain that you will do this for her.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING PERINEAL CARE TO THE FEMALE PATIENT	DEMONSTRATION/COMMENTS
3. Position your patient on the bedpan with her knees bent and her legs spread apart. If she has a Foley catheter, be careful not to put any tension on the catheter. Make sure she is carefully screened. Gown will cover top torso.	3. ____________________
4. Soap up the washcloth and clean the outer perineum and the area between the thighs.	4. ____________________
5. Separate the folds of tissue that cover the vaginal area (called the labia) and wash over the urinary opening (called the meatus) and the vagina. Clean with firm, downward strokes, moving from the top of the perineum down towards the rectum. USE ONLY DOWNWARD STROKES, DO NOT WASH UPWARD. By cleaning in this manner, you are cleaning from an area that is clean to an area that is dirty. Do not contaminate a clean area with secretions from a dirty area.	5. ____________________



LEARNING ACTIVITIES - continued

PROCEDURE: GIVING PERINEAL CARE TO THE FEMALE PATIENT	DEMONSTRATION/COMMENTS
6. Change to a clean part of the washcloth after EACH downward stroke. Again, if you use a clean part of the washcloth each time, you will not contaminate a clean area with secretions from a dirty area.	6. ____________________
7. Rinse the perineum by pouring the warm water in the measuring container over the perineum. Dry thoroughly with the hand towel.	7. ____________________
8. Remove the bedpan and place the patient on her side. Separate the buttocks, wash and dry the posterior area with special attention to the anal region.	8. ____________________

Procedure for Giving Perineal Care to the Male Patient

Directions: Read the following procedures. Then demonstrate each procedure for your instructor who will check off the steps as you accomplish them.

PROCEDURE: GIVING PERINEAL CARE TO THE MALE PATIENT	DEMONSTRATION/COMMENTS
1. Wash your hands and collect the following equipment: basin with warm water, soap, washcloth, hand towel.	1. ____________________
2. If your patient is unable to finish his bath, explain that you will do this for him.	2. ____________________
3. Drape your patient exposing his penis and scrotum. If he has not been circumcised, work back the foreskin to expose the tip of the penis.*	3. ____________________

*If he has been circumcised, you will not have to pull back the foreskin since there will be none.

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING PERINEAL CARE TO THE MALE PATIENT	DEMONSTRATION/COMMENTS
4. Soap up the washcloth and clean around the penis and under the foreskin until free of all secretions. Rinse and dry thoroughly. Pull the foreskin back over the tip of the penis.	4. ____________________
5. Wash the outside of the foreskin and the penis. Separate the legs. Wash the scrotum and the inner thighs. Rinse and dry thoroughly.	5. ____________________
6. Ask the patient to turn to his side. Separate the buttocks, wash and dry the area from the scrotum to the anus.	6. ____________________

ACTIVITY #3. Giving Mouth Care

Directions: Read the following paragraph.

Mouth care or oral hygiene is care of the mouth and teeth. This should be done at least three times a day. Encourage your patient to do as much for himself as possible. Special oral hygiene is the cleaning of the mouth to a helpless or unconscious patient. Patients who are unconscious often require more frequent mouth care than others.

Procedure for Giving Routine Oral Hygiene

PROCEDURE: GIVING ROUTINE ORAL HYGIENE	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the following equipment: toothbrush, toothpaste or powder, mouthwash solution in a cup, emesis basin, bath towel, and a cup of fresh water.	1. ____________________
2. Tell the patient what you plan to do.	2. ____________________
3. Place the bath towel under the patient's chin and over the gown and bedcovers.	3. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING ROUTINE ORAL HYGIENE	DEMONSTRATION/COMMENTS
4. Pour water over the toothbrush and apply the toothpaste. Insert the brush into the patient's mouth with bristles in a downward position. Turn the toothbrush with bristles toward the teeth and brush all tooth surfaces with an up-and-down motion. Brush the teeth carefully and thoroughly.	4. ______________________
5. Give the patient water in a cup to rinse the mouth and have him spit in the emesis basin. Offer the mouthwash.	5. ______________________
6. Wipe the mouth and chin with the towel and remove it.	6. ______________________
7. Rinse the toothbrush with water.	7. ______________________

Procedure for Giving Special Oral Hygiene

PROCEDURE: GIVING ROUTINE ORAL HYGIENE	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the following equipment: mouthwash in a cup, emesis basin, bath towel, cotton-tip applicators, tongue depressor, and lubricant (like vasoline).	1. ______________________
2. Tell the patient what you plan to do - even if he is unconscious and does not seem to hear you.	2. ______________________
3. Cover the pillow with the towel and turn the patient's head to one side. Place the emesis basin under the patient's chin. Open the mouth gently with the tongue depressor.	3. ______________________
4. Dip the cotton-tip applicator in the mouthwash solution and wipe the gums, teeth, tongue, and the inside of the mouth. Repeat the procedure as often as necessary to thoroughly clean mouth.	4. ______________________
5. Lubricate the lips.	5. ______________________

LEARNING ACTIVITIES - continued

Procedure for Care of Dentures

Directions: View the filmloop, Care Of Dentures by J. B. Lippincott.

PROCEDURE: CARE OF DENTURES	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the following equipment: toothbrush or denture brush, mouthwash, toothpaste or powder, denture cup, paper towels.	1. ________________
2. Tell the patient what you plan to do.	2. ________________
3. Ask your patient to remove the dentures. Assist if necessary. Place dentures in the denture cup and take them to the bathroom.	3. ________________
4. Line the bathroom sink with paper towels to protect the dentures if you drop them. Put the toothpaste on the brush. Place the dentures in the palm of your hand and hold them under a gentle stream of warm water. Brush until all the surfaces are clean.	4. ________________
5. Rinse the dentures thoroughly under cold running water and place them in a clean denture cup. Take them to the patient.	5. ________________
6. Assist the patient to rinse the mouth with mouthwash before the dentures are replaced. Hand the dentures back to the patient to reinsert. Help insert, if necessary.	6. ________________

ACTIVITY #4. Making Nursing Observations During the Bath

Directions: Read the following information.

While bathing your patient, you must make nursing observations about your patient's condition. Use your special senses when making observations:

1. SIGHT: Do you see any swelling, reddness, rashes, bruises, irritations, unusual discharge or drainage?
2. SMELL: Do you notice any odor from a cast, a wound, the breath, the urine, the perineal area?

LEARNING ACTIVITIES - concluded

3. TOUCH: Does your patient complain of pain when you touch a certain area? Is a reddened area also warm to the touch? Are the toes of the foot in a cast cold to the touch?

4. HEARING: What does your patient's breathing sound like? Does she sound "bubbly" when she is lying on her left side? What does she sound like when she coughs?

Bath time is also a good time to learn to talk with your patients. Remember, when you talk with a patient, you usually do more LISTENING than talking. Ask about her condition, find out why she first went to the doctor; learn about the family and how they are affected by her being hospitalized. In listening carefully, you will not only learn much about her condition but may also note some emotional changes. The patient may be discouraged, angry, depressed, apprehensive, disgusted or hopeful. A patient's state of mind very often affects his/her ability to satisfactorily recover from an illness.

All observations must be reported to the nurse in charge.

ACTIVITY #5. Demonstration of What You Have Learned

Directions: Now, take the pages in this module to your instructor. Using another student as a patient, demonstrate a complete bed bath and mouth care.

Using Mrs. Chase, the mannequin, demonstrate perineal care.

Exercise. Observations

Directions: Write down at least five "observations" you made during the demonstration of a bed bath and mouth care, about your "patient's" physical condition and personality.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

NOTE: Modules C1 and C2 may be done at this time in conjunction with the bed bath.

NURSING ASSISTANT SKILLS

Module A3 - Take Vital Signs

RATIONALE

Remember the times when you have felt overheated, or have noticed your heart beating harder, or that you were breathing faster? These feelings are usually the normal result of exercise, excitement, anxiety, or fear. However, these feelings are also very important signs of disease or disorders of the body. In this part of Module A, you will learn how to measure four of these important signs, namely: temperature, pulse, respirations, and blood pressure.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction you will:

1. Demonstrate and answer written questions relating to the procedure for measuring each of these vital signs:
    a. Temperature (oral, axillary, and rectal)
    b. Pulse (radial and apical)
    c. Respirations
    d. Blood pressure
2. Identify the normal rates for each of these vital signs.
3. Identify reasons for the changes in normal rates of vital signs.
4. Identify the instruments used to measure the temperature and the blood pressure.
5. Identify the names of arteries where the pulse can be found.
6. Recognize the abbreviations used to order how frequently vital signs should be taken.

LEARNING ACTIVITIES

Directions: This part of Module A is also very long and the information is very important, so GET BUSY!! Read all of the material and answer the questions. You will be asked to view two Trainexes. You will also demonstrate each procedure to your instructor and will need to practice until you are accurate. Remember, if you need help, get it from your instructor.

LEARNING ACTIVITIES - continued

ACTIVITY #1. Vital Signs

Directions: Read the following information about vital signs.

Temperature, pulse, respirations, and blood pressure are called the vital signs. These are four signs that can be measured during a patient's illness to help the physician to better understand the patient's condition and to help him watch for changes in the condition. The word vital means very important or essential to life. Vital signs are very important signs that are essential to life.

You will be measuring the patient's temperature, pulse, and respirations usually all at the same time. This is called taking a patient's TPR. The blood pressure or BP is also taken at the same time as the TPR. The doctor will usually order how frequently he wishes the patient's vital signs to be taken. Vital signs may be taken:

1. q.i.d. - Four times a day; vital signs are taken twice on the morning shift and twice on the evening shift.
2. t.i.d. - Three times a day or twice on the morning shift and once on the evening shift.
3. b.i.d. - Twice a day or once on the morning shift and once on the evening shift.
4. q.d. - Once a day on the morning shift.
5. q.4.h. - Every four hours which means that vital signs are taken twice on every shift and includes awakening the patient at night.
6. q. 15 min. x 6 - Every fifteen minutes for six times or six times in 1 1/2 hour at 15 minute intervals.

If the doctor does not write an order for vital signs or orders routine vitals, the vital signs are taken q.i.d. for the first 48 hours after the patient is admitted to the health care facility or after the patient has returned from surgery. Then the nurse in charge will decide how often you will need to take the patient's vital signs. Each facility will have its own routine.

In the average, healthy person the vital signs stay very close to the same rate. They may change for a period of time when the person is very active or excited or under some emotional stress, but, will soon return to their usual rate. These usual rates are called the normal rates. The normal rates for the average person are:

Temperature: 98.6° F (37° C)

Pulse: 72 heart beats per minute

Respirations: 16 to 20 per minute

Blood Pressure: 120/80

LEARNING ACTIVITIES - continued

Exercise

Directions: Answer these questions pertaining to vital signs. Answers can be found in the preceding information.

1. The four signs that are called vital signs are:

   a. __________ b. __________ c. __________ d. __________

2. The word vital means: ________________ ______ ________________.

3. What does BP stand for? ______________________________.

4. What does TPR stand for? ______________________________.

5. You work on the 7-3 shift. The doctor orders that your patient's vital signs be checked t.i.d. How often will you take this patient's vital signs? ______________________.

6. The doctor has ordered vital signs q.i.d. What does q.i.d. stand for? ____

7. If you work on the evening shift or the 3-11 shift, how often will you take a patient's vital signs when ordered q.i.d.? ______________________________

8. If the doctor has ordered that the patient's vital signs be taken q.d., the patient will have to be awakened during the night for vital signs. Circle the correct answer. TRUE FALSE

9. If the doctor ordered vital signs q.4.h., how often should they be taken? ____

10. Vital signs will often change when the person is sick. When else might there be a change in the vital signs that does not necessarily indicate a disease? ____

11. What is the normal rate for each of these vital signs?

    Temperature: __________________ Pulse: __________________
    Respirations: __________________ Blood Pressure: ____________

LEARNING ACTIVITIES - continued

ACTIVITY #2. Temperature

Directions: Read the following material.

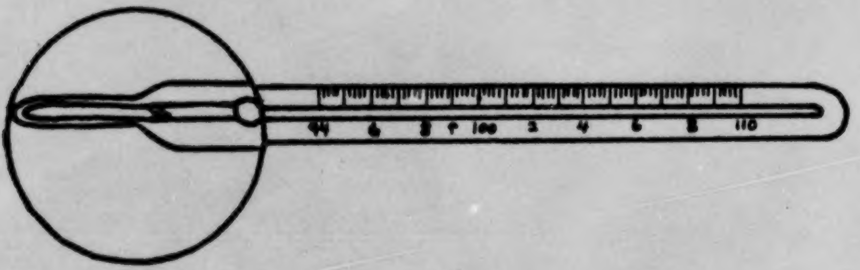
The body produces heat as it burns up the food we eat for energy. Some of this heat is lost from the body through perspiration, respiration, and excretion. Body temperature is a measurement of the balance between the heat produced by the body and the heat lost.

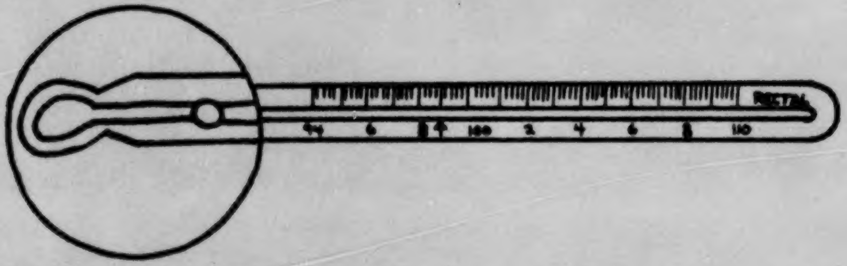
Body temperature is affected by many different things. Sometimes a person's temperature may rise if he is exercising or is emotionally distressed. The temperature may be slightly changed after a person has had a drink or has eaten something cold or hot. When a person has an infection, his temperature will usually be higher than normal. If the person has a temperature above normal, he is said to have a fever.

Body temperature is measured with an instrument called a thermometer. The thermometer contains mercury which is an element that is very sensitive to heat. When the patient's temperature is above normal, the mercury will travel up the thermometer. There are three types of thermometers. The oral thermometer, the rectal thermometer, and the electronic thermometer. NEVER use an oral thermometer to take a temperature in the rectum and NEVER use a rectal thermometer to take a temperature in the mouth. You can tell the difference between the thermometers in several ways:

1. By the mercury tip - sometimes the mercury tip may be different. The oral thermometer may have a long pointed tip or a round tip. The rectal thermometer usually has a round bulb-like tip.

2. By the color of the end - the end of the rectal thermometer may be colored red. Many thermometers will be marked rectal.

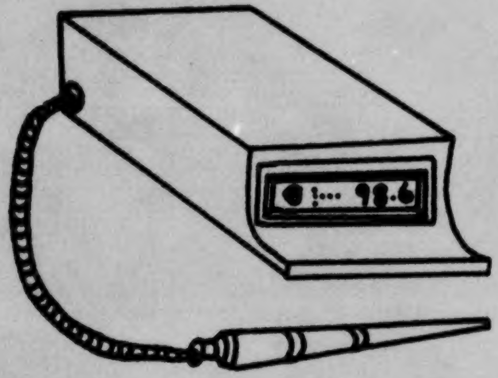




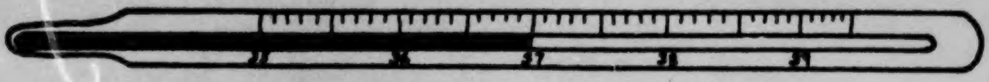
Compare the tips of these thermometers. Notice the difference?

LEARNING ACTIVITIES - continued

3. The electronic thermometer is currently used in some health care facilities. It registers the temperature on the viewer in a few seconds. One unit can be used for many patients by simply changing the disposable tip after each patient.



Reading the Centigrade Thermometer

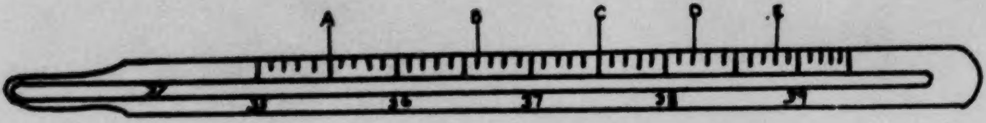


Each line on a centigrade thermometer equals .1° or 1/10 of 1°. The reading above would be 37° C (normal oral temperature).

Exercise 1.

Directions: In the spaces below, record the centigrade readings at each arrow. Answers can be found on page 19 of this module.

A _________ B _________ C _________ D _________ E _________



LEARNING ACTIVITIES - continued

There are three ways of taking a patient's temperature.

1. Oral: Taken in the mouth using the oral thermometer; normal oral temperature is 98.6° F (37° C).
2. Axillary: Taken under the armpit using the oral thermometer; normal axillary temperature is 97.6° F (36.5° C).
3. Rectal: Taken in the rectum using the rectal thermometer; normal rectal temperature is 99.6° F (37.6° C).

Some rules to remember when taking a temperature are:

1. The temperature reading MUST BE ACCURATE. Practice until you are sure you are reading the thermometer correctly. If you have any questions or are unsure, check your reading with your instructor. If your reading is much lower or much higher than you would expect from a patient, get a new thermometer and take a temperature again. Do not take a temperature after the patient has had something hot or cold to eat or drink or has been smoking.
2. Always clean the thermometer before putting it into the patient's mouth or rectum. Make sure you use the patient's own thermometer to take his temperature. Do not borrow another patient's thermometer. Dirty thermometers spread disease.
3. Never clean a thermometer in hot water.
4. Never take an oral temperature on a small child, confused or unconscious patient, or a patient who cannot keep his mouth closed such as a mouth-breathing patient, or a patient with a tube in his nose. Use a rectal thermometer instead.
5. Handle all thermometers carefully. They break easily.

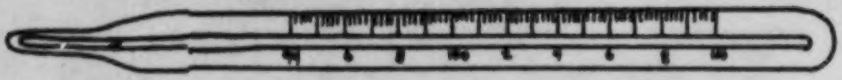
Exercise 2.

Directions: View the first part of the Trainex, Temperature, Pulse, and Respirations and write the answers to the following questions. Answers can be found on page 19 of this module.

1. If the patient has a temperature above normal, she is said to have a ______________________.
2. Body temperature is measured with an instrument called a ________________ .
3. Two types of thermometers are ____________________ and ________________ .

LEARNING ACTIVITIES - continued

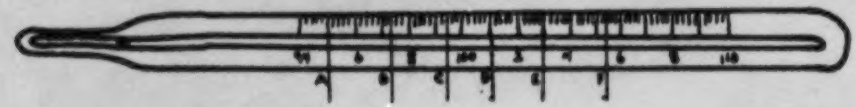
4. Label the parts of the thermometer on this diagram.



A. ____________ B. ____________

5. Thermometers are marked in ______________________________.

6. Read each of the following temperatures at the line as marked on the diagram of a thermometer:



A. _____ B. _____ C. _____ D. _____ E. _____ F. ______

7. When taking an oral temperature, the thermometer is left in the mouth ______ minutes.

8. The normal oral temprature is ______ ° F.

9. The ____________ temperature is taken under the armpit and the thermometer is left in place _______ minutes.

10. A normal axillary temperature is _______ ° F.

11. The rectal thermometer is left in place _______ minutes.

12. A normal rectal temperature is _______ ° F.

Procedure for Taking an Oral Temperature

Directions: Read these procedures. When you demonstrate each procedure, your instructor will make comments on the steps as you accomplish them.

PROCEDURE: TAKING AN ORAL TEMPERATURE	DEMONSTRATION/COMMENTS
1. Collect equiment: oral thermometer, watch, pencil, paper.	1. __________________________

LEARNING ACTIVITIES - continued

PROCEDURE: TAKING AN ORAL TEMPERATURE	DEMONSTRATION/COMMENTS
2. Tell the patient that you are going to take his temperature.	2. ______________________
3. Clean the thermometer with cool water and shake it down to 94° F or 35.5° C.	3. ______________________
4. Place the bulb of the thermometer under the patient's tongue. Ask the patient to close his mouth.	4. ______________________
5. Check your watch. After three minutes, remove the thermometer, clean it, and check the reading.	5. ______________________
6. Immediately record the temperature on paper. If the temperature is elevated, recheck it and then report it to the nurse in charge.	6. ______________________
7. Clean and rinse the thermometer in cool water.	7. ______________________

Procedure for Taking an Axillary Temperature

PROCEDURE: TAKING AN AXILLARY TEMPERATURE	DEMONSTRATION/COMMENTS
1. Collect equipment: oral thermometer, watch, pencil, paper.	1. ______________________
2. Tell your patient what you are going to do. Dry the underarm thoroughly.	2. ______________________
3. Clean the thermometer and shake it down to 94° F or 35.5° C.	3. ______________________
4. Place the bulb of the thermometer in the center of the axilla or armpit and cross the patient's arm over his chest.	4. ______________________
5. Check your watch. After ten minutes, remove the thermometer and check the reading.	5. ______________________

LEARNING ACTIVITIES - continued

PROCEDURE: TAKING AN AXILLARY TEMPERATURE	DEMONSTRATION/COMMENTS
6. Record the reading. Mark that this is an axillary temperature by using the symbol Ax.	6. ____________________
7. Clean and rinse the thermometer in cool water.	7. ____________________

Procedure for Taking a Rectal Temperature

PROCEDURE: TAKING A RECTAL TEMPERATURE	DEMONSTRATION/COMMENTS
1. Collect equipment: rectal thermometer, lubricant, watch, pencil, paper.	1. ____________________
2. Tell your patient what you are going to do and screen the patient. Turn the patient to his side.	2. ____________________
3. Clean the thermometer and shake it down to 94° F or 35.5° C.	3. ____________________
4. Lubricate the bulb end of the thermometer about 1 1/2 inches.	4. ____________________
5. Insert the thermometer about 1 to 1 1/2 inches into the rectum. Be very careful.	5. ____________________
6. Check your watch. Hold the thermometer in place for five minutes. Remove the thermometer, clean, and check the reading.	6. ____________________
7. Record the reading. Be sure to mark that this is a rectal temperature with an R after your reading.	7. ____________________
8. Clean and rinse the thermometer with cool water.	8. ____________________

LEARNING ACTIVITIES - continued

Exercise 3. Demonstrate Taking Temperatures

Directions: Take your module to your instructor. Using another student as your patient, demonstrate to your instructor the procedure for taking an oral and an axillary temperature. Use the mannequin to demonstrate the rectal temperature.

ACTIVITY #3. Pulse

Directions: Read this information.

When your heart beats, it pumps blood into the blood vessels called arteries. The force of the blood being pumped into the artery causes the walls of the artery to expand. The force of the heart as it pumps the blood and causes the walls of the arteries to expand is called the pulse. The number of heart beats each minute is the pulse rate. The pulse rate measures how fast the heart is beating. The heart pumps blood at a very steady pace with about the same amount of time between each beat. The regularity of the pulse beats is called the pulse rhythm. When you check a pulse, you report three things about the pulse, you report:

1. rate - the number of beats per minute
2. rhythm - how steady and regularly the pulse beats
3. volume - the strength of the pulse

In the average, healthy adult, the normal pulse rate is about 72 beats per minute and the rhythm is regular. Normal pulse rates vary with the age and the sex of the patient.

Men: 60--70 beats per minute

Women: 70--80 beats per minute

Children over 7 years of age: 80--90 beats per minute

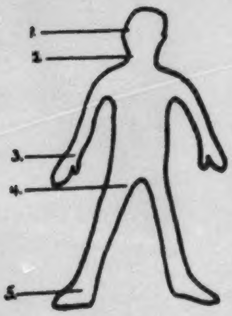
Children 1 to 7 years of age: 80--120 beats per minute

Infants: 110-130 beats per minute

As the patient gets older, the rhythm of the pulse may also change. Instead of being regular, the pulse may become irregular. An irregular pulse is one that skips beats or may beat rapidly for a short time and then slowly, or, it may beat regularly for a time and then suddenly beat two or three quick beats.

Remember, when you measure a pulse, you are feeling an artery. Some of these arteries are very close to the surface of the body and you can feel the pulse. The pulse will usually be named by the artery that you feel. You can feel a pulse in these arteries.

LEARNING ACTIVITIES - continued



1. temporal - at the side of the head above the ear
2. carotid - in the neck next to the esophagus
3. radial - in the wrist on the thumb side
4. femoral - in the groin
5. pedal - on the top of the foot or the inside of the foot under the ankle

The pulse rate is usually taken at the radial artery. However, if the pulse is irregular, you should not try to take the pulse by feeling the artery. You must listen to the heart with an instrument called a stethoscope and count the number of heart beats per minute. This type of pulse is called an apical pulse. If you feel the need to review apical pulse, refer to the Trainex on Temperature, Pulse and Respirations.

Procedure for Taking a Radial Pulse

Directions: Read the following procedure. When you demonstrate the procedure, your instructor will make comments on the steps as you accomplish them.

PROCEDURE: TAKING A RADIAL PULSE	DEMONSTRATION/COMMENTS
1. Tell your patient that you are going to take her pulse.	1. ____________________
2. Position the patient's arm so that it is relaxed and resting comfortably.	2. ____________________
3. Find the pulse in the radial artery on the thumb side of the wrist. Remember to use your first three fingers, not your thumb and to press lightly with only enough pressure to feel the pulse distinctly.	3. ____________________
4. When you feel the pulse, look at the second hand on your watch and count the beats for one minute. Remember to also note the rhythm of the pulse.	4. ____________________
5. Immediately record the pulse rate and rhythm. If the rhythm is irregular, take an apical pulse. Report rhythm irregularities and rates that are unusually slow or fast to the nurse in charge.	5. ____________________

LEARNING ACTIVITIES - continued

ACTIVITY #4. Respirations

Directions: Read the following material.

You cannot live without air. To get air into your body, you must breathe. When you breathe in or inhale, air is sucked into your lungs; when you breathe out or exhale, air is forced back out of the lungs. This process of inhaling and exhaling is called respiration. One respiration includes breathing in once and breathing out once. When you inhale, your chest gets larger and will rise; when you exhale, the chest gets smaller and will fall. To count respirations, your patient should be lying on his back. You will either watch or feel his chest rise and fall. You will usually count respirations immediately after taking the pulse. If you leave your hand in place as if you are still taking the pulse, your patient will not know that you are counting the respirations. Sometimes, if the patient is aware that you are taking his respirations, he will not breathe naturally. The normal respiratory rate for an adult is from 16 to 20 times per minute. Children breathe more rapidly. For example, an infant's respiratory rate is around 30 per minute.

When counting the respiratory rate, you must also note the character of the patient's respirations. Does he breathe easily or is it hard for him to breathe? Can he breathe easily only when sitting up? Does he make a wheezy sound or a gurgly sound when he breathes?

Two things to watch when counting respirations are:

1. the rate

2. the character of respirations

Procedure for Taking Respirations

Directions: Read the following procedure. When you demonstrate the procedure, your instructor will make comments on the steps as you accomplish them.

PROCEDURE: TAKING RESPIRATIONS	DEMONSTRATION/COMMENTS
1. Do not tell the patient you are counting the respirations. Count them as you hold the patient's wrist as though you were taking the pulse.	1. ____________________
2. Count each rise and fall of the chest as one respiration. Count for one minute. At the same time that you count respiratory rate, note the character of the patient's respirations.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: TAKING RESPIRATIONS	DEMONSTRATION/COMMENTS
3. Immediately record the rate. Notify the nurse in charge if the character of respirations has changed and if the rate is slower or faster than normal.	3. ______________________

Exercise 1.

Directions: View the second part of the Trainex, Temperature, Pulse, and Respirations. After viewing the Trainex, answer these questions. Answers can be found on page 19 of this module.

1. The pulse rate measures the number of ______ per minute of the __________ .
2. Besides counting the rate, you must also report the ______ of the pulse.
3. The normal pulse rate for men is ____ to ____ beats per minute.
4. The normal pulse rate for women is ____ to ____ beats per minute.
5. When the pulse skips beats, it has an __________________ rhythm.
6. The pulse rate is usually taken at the ___________ artery.
7. It may also be taken at an artery in the neck. This pulse is called the ____________ pulse.
8. If you must listen to the heartbeat with a stethoscope, the pulse is called an __________________ pulse.
9. When would you take an apical pulse? ______________________________
10. When you breathe in, you ____________; when you breath out, you ____________.
11. Respiration is the process of ___________ and ____________.
12. The normal respiratory rate in an adult is from ________ to ________ times per minute.
13. When checking respirations, you must count the rate and note the __________ .

Exercise 2. Demonstrate Taking the Pulse and Respirations

Directions: Take the checklist in your module to your instructor. Choose another student as your patient and demonstrate to your instructor the procedure for taking the pulse and respirations.

LEARNING ACTIVITIES - continued

ACTIVITY #5. Blood Pressure

Directions: Read this information.

Blood pressure is the force exerted by the blood against the walls of the artery as it is pumped by the heart. Blood pressure measures the pressure within an artery. When the heart is beating, the pressure is at its highest point. This pressure is called the systolic pressure. When the heart is relaxed between beats, the pressure is at its lowest point. This pressure is called the diastolic pressure. When taking the blood pressure, you measure both the systolic pressure and the diastolic pressure. The normal systolic pressure for an average, healthy adult is 120. The normal diastolic pressure is 80. Then, normal blood pressure would then be 120/80.

Blood pressure will change if there are changes in:

1. The arteries: If the arteries are smaller or constricted, the blood pressure will go up; if the arteries are larger or dilated, the blood pressure will go down. Arteries are also able to stretch like elastic to accommodate the blood that is forced into them. If they become hardened and lose their elasticity, the pressure exerted by the blood against the walls of the arteries is much greater and the blood pressure goes up.

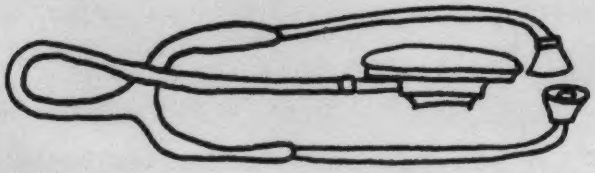
2. The heart: The force of the beat of the heart and the rate of the heartbeat will also change the blood pressure. If the force of the beat of the heart is greater or the rate faster, the blood pressure will go up; if the force is weak, the blood pressure goes down.

3. The blood volume: Blood volume is the amount of blood flowing through the artery. If a patient hemorrhages or suddenly looses a large amount of blood, there is not much blood flowing in the arteries and the blood pressure will go down.

4. The pressure on the brain: When a patient has a brain tumor or a head injury, sometimes the pressure exerted against the brain increases. When this happens, the blood pressure goes up.

To measure a patient's blood pressure, you will need two instruments: the stethoscope and the sphygmomanometer. The stethoscope is an instrument used to listen to sounds in the patient's body like the sound of the heartbeat or the breathing in the lungs or the movement of the intestine. You will use a stethoscope to listen to the heartbeat as it sounds in an artery in the patient's arm.

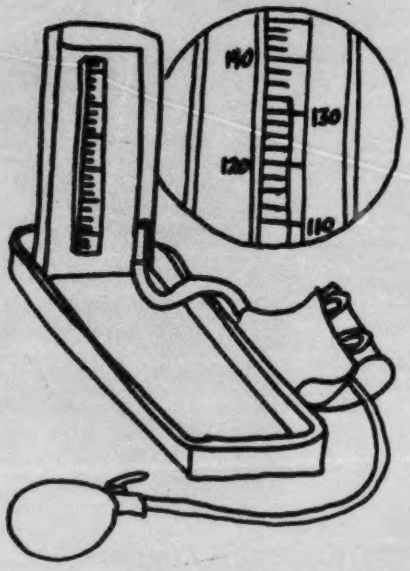
STETHOSCOPE



LEARNING ACTIVITIES - continued

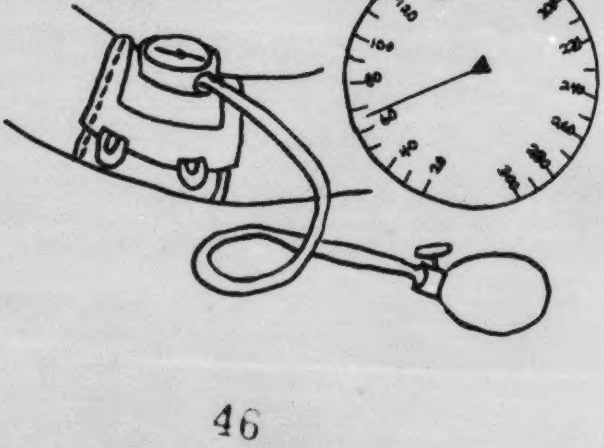
At the same time that you are listening to the pulse in the arm, you will be watching a column of mercury or a dial on the sphygmomanometer. The sphygmomanometer measures the blood pressure. There are two types of sphygmomanometers.

One type measures the blood pressure as you watch the level of a column of mercury on a measuring scale; the other type measures the blood pressure using a pointer on a dial.


140
130
120
110

MERCURY SCALE
SPHYGMOMANOMETER

DIAL TYPE
SPHYGMOMANOMETER

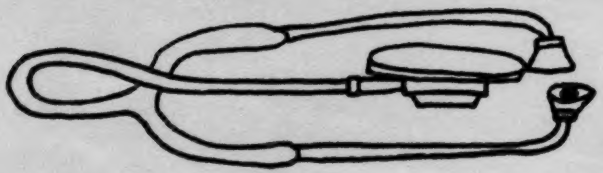

20
40
60
80
100
120
140
160
180
200
220
240
260
280
300

LEARNING ACTIVITIES - continued

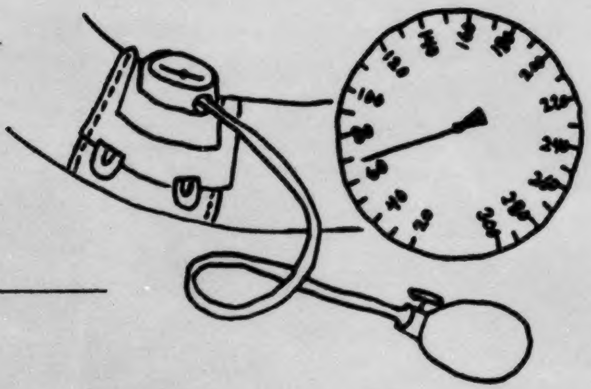
Exercise 1. Taking Blood Pressure

Directions: View the Trainex on Blood Pressure. After viewing the Trainex, answer these questions. Answers can be found on page 19 of this module.

1. Label the following instruments:



A. ____________________



B. ____________________

2. Blood pressure is the force of the blood against the walls of the __________ as it is pumped by the heart.
3. Blood pressure measures both the highest pressure called the __________ __________ and the lowest pressure called the ______________ pressure.
4. The normal blood pressure for an adult is ____________.
5. If the blood pressure is 110/70, ____________ is the systolic pressure and ____________ is the diastolic pressure.

LEARNING ACTIVITIES - continued

6. The blood pressure will change if the arteries are suddenly dilated. Circle the correct answer. TRUE FALSE

7. To dilate means to get (smaller, larger). Circle the correct answer.

8. To constrict means to get (smaller, larger). Circle the correct answer.

9. If an older patient has hardening of the arteries, his blood pressure will be much lower than normal. Circle one. TRUE FALSE

10. The sudden loss of a large amount of blood is called ______________________.

11. When a patient loses a large amount of blood, the blood pressure will drop. Circle the correct answer. TRUE FALSE

Procedure for Taking the Blood Pressure

Directions: Read the procedure below. When you demonstrate the procedure, your instructor will make comments on the steps as you accomplish them.

PROCEDURE: TAKING THE BLOOD PRESSURE	DEMONSTRATION/COMMENTS
1. Collect equipment: stethoscope, sphygmomanometer, pencil, paper.	1. ________________________
2. Tell the patient that you are going to take her blood pressure. The patient should be resting quietly, preferably lying flat in bed.	2. ________________________
3. Expose the patient's arm to her shoulder and wrap the blood pressure cuff snugly around the arm about one inch above the bend in the elbow.	3. ________________________
4. Place the earpieces on the stethoscope in your ears. Make sure that the earpieces point in towards your face.	4. ________________________
5. Find the pulse inside the center of the bend in the elbow and place the stethoscope where you feel the artery.	5. ________________________

LEARNING ACTIVITIES - concluded

PROCEDURE: TAKING THE BLOOD PRESSURE	DEMONSTRATION/COMMENTS
6. Take the blood pressure. Remember to listen for the first clear sound. This sound is the systolic pressure. Then listen carefully for the change in the sound to a muffled thump. This sound is the diastolic pressure.	6. ____________________
7. Recheck the blood pressure.	7. ____________________
8. Release all the air from the cuff and remove it. Immediately record the blood pressure reading. If the blood pressure is high or lower than the patient's usual blood pressure, report it to the nurse in charge.	8. ____________________

Exercise 2. Taking Blood Pressure

Directions: Take your module on taking BLOOD PRESSURE to your instructor. Ask another student to be your patient and demonstrate to your instructor the procedure for taking blood pressure.

Exercise 3. Blood Pressure, Pulse, and Respirations

Directions: Now, choose five classmates and take their blood pressure, pulse, and respirations. Record these rates in the spaces provided below and show your results to your instructor.

NAME:____________________ PULSE:______ RESPIRATION______ BP_____

NAME:____________________ PULSE:______ RESPIRATION______ BP_____

NAME:____________________ PULSE:______ RESPIRATION______ BP_____

NAME:____________________ PULSE:______ RESPIRATION______ BP_____

NAME:____________________ PULSE:______ RESPIRATION______ BP_____

ANSWERS

ACTIVITY #2

Exercise 1

A. 35.5° C
B. 36.6° C
C. 37.5° C
D. 38.2° C
E. 38.8° C

Exercise 2

1. fever
2. thermometer
3. rectal, oral
4. A. bulb
   B. stem
5. degrees
6. A. 95° F
   B. 97.2° F
   C. 98.6° F (37° C)
   D. 101° F
   E. 102.8° F
   F. 105.4° F
7. three
8. 98.6° F
9. axillary, 10
10. 97.6° F
11. 5
12. 99.6° F

ACTIVITY #4

Exercise 1

1. beats, heart
2. rhythm
3. 60, 70
4. 70, 80
5. irregular
6. radial
7. carotid
8. apical
9. when the pulse is irregular
10. inhale, exhale
11. inhalation, exhalation
12. 16, 20
13. character

ACTIVITY #5

Exercise 1

1. A. stethoscope
   B. sphygmomanometer
2. arteries
3. systolic, diastolic
4. 120/80
5. 110, 70
6. TRUE
7. larger
8. smaller
9. FALSE
10. hemorrhage
11. TRUE

RATIONALE

The body takes in a certain amount of fluids everyday and eliminates some of these liquids as wastes. When a person is ill or has had surgery, the fluid intake or the fluid output may be disrupted. As you care for patients in a health care facility, you will be responsible for carefully measuring their liquid intake and output.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate and answer written questions relating to the procedure for measuring and recording fluid intake and output.
2. Identify foods which are fluids.
3. Identify sources of liquid output.
4. Identify the reasons why a patient may need to force fluids.

LEARNING ACTIVITIES

Directions: This is the last part of Module A. All of the information you will need to complete this section is included. Be sure to do all of the activities and have your instructor check your work. If you need any help, your instructor is available.

ACTIVITY #1. Fluid Balance

Directions: Read the following material.

Water is essential to human life. About two-thirds of your body weight is water. That means, that if you weigh 120 pounds, 80 pounds of your weight is water. Every cell in your body contains water. All of your cells are surrounded by fluid and about half of your blood is made up of water. Losing only one-fifth of the body's fluid will result in death.

The average adult eats and drinks about 3 1/2 quarts of fluids a day. This is called the fluid intake. A person will also excrete about 3 1/2 quarts of fluid a day. This is called the fluid output. The fluid intake and output are balanced. A fluid balance means that the same amount of fluid taken in by the body is also excreted.

LEARNING ACTIVITIES - continued

Fluid may be excreted from the body in four different ways:

1. through the skin - as perspiration
2. through the lungs - as some fluid is evaporated when you breathe
3. through the intestinal system - as part of the stools
4. through the kidneys - as urine

About 1 1/2 quarts of fluid are excreted daily as urine. Since it is difficult to accurately measure the amount of fluid lost as perspiration or when breathing, it is very important to measure the amount of fluid lost as urine. Other important sources of liquid output that can be measured include vomit, liquid diarrhea stool, and any drainage from tubes inserted in the patient's body.

The only way that the doctor can determine that the fluids in the body are balanced is to measure all of the fluids that the patient takes in and to measure the fluids that the patient excretes. This is called measuring the intake and the output. Intake and output are recorded on a special sheet known as the "I & O" sheet. Intake and output are not measured by using cups, ounces, and quarts; but, are measured using cubic centimeters or cc's. Some of the most common ones used are:

30 cc = 1 ounce
250 cc = 1 cup
500 cc = 1 pint
1000 cc = 1 quart

So, if the average person drinks about 3 1/2 quarts of fluid a day, what he drinks is equal to 3500 cc's of fluid (1000 cc x 3 1/2 qt). One and a half quarts of urine equals 1500 cc's of urine (1000 cc x 1 1/2).

Foods that are considered to be fluids include:

1. pudding
2. jello
3. ice cream
4. cream of wheat
5. all fluids

Check with the nurse in charge if you have any questions.

LEARNING ACTIVITIES - continued

Exercise 1.

Directions: Answer the following questions. Answers can be found in the preceding material.

1. Because water is essential to life, you cannot live if you are losing more fluids than you are able to take in. Circle one. TRUE FALSE

2. All fluid that is taken into the body is known as __________ __________.

3. The fluid that the body excretes is called __________ __________.

4. In the average, healthy adult the fluid taken in equals the fluid excreted. This means that the fluid intake and output are __________.

5. Fluid may be lost from the body in four different ways. List the four ways.

   a. __________ c. __________

   b. __________ d. __________

6. Four important sources of liquid output that can be measured include:

   a. __________ c. __________

   b. __________ d. __________

7. Intake and output are measured in __________ (unit of measurement).

Procedure for Measuring Intake

Directions: Read the procedure below and on the following page. When you demonstrate this procedure, your instructor will make comments on the steps as you accomplish them.

PROCEDURE: MEASURING INTAKE	DEMONSTRATION/COMMENTS
1. Explain to the patient that the fluid intake is being measured. Fluid intake includes: (1) water, (2) ice chips, (3) milk, (4) juice, (5) soup and/or broth, (6) tea, (7) coffee (8) ice cream, and (9) jello.	1. __________
2. Check the patient's tray immediately after he has finished eating (before the tray is removed). Ask the patient how many glasses of water, juice, coffee, tea, or other fluids he has taken between meals.	2. __________

LEARNING ACTIVITIES - continued

PROCEDURE: MEASURING INTAKE	DEMONSTRATION/COMMENTS
3. Estimate the amount of liquid intake after each time the patient takes fluids and convert the liquid intake into amount in cc's.	3. ____________________
4. Record the amount in cc's under the intake column on the Intake and Output sheet. See an example of a record on the following page.	4. ____________________
5. Add up the total fluid intake for the eight hours that you have cared for this patient and mark it in the box labeled "8 Hr. Total".	5. ____________________

CONTAINER	
Individual creamer	15 cc
Jello	75 cc
Plastic-covered juice container	90 cc
Ice cream	90 cc
Soup bowl	120 cc
Tea cup	150 cc
Waxed cold cup	180 cc
Styrofoam cup	180 cc
Water glass	200 cc
Ice tea glass	300 cc
Paper-hot drink soup	200 cc
Coffee pot	240 cc
Milk carton	240 cc
Water pitcher	800 cc
Ice chips in water glass	90 cc

NOTE: Fluid intake also includes intravenous fluids. The nurse in charge is responsible for computing IV fluid intake and adding it onto the I & O sheet.

LEARNING ACTIVITIES - continued

SAMPLE
INTAKE AND OUTPUT SHEET

From 0600 Date ________________ To 0600 Date ________________

INTAKE **OUTPUT**

TIME	PO				TIME	URINE	STOOL			OUTPUT TESTS
0700					0700					
0800					0800					
0900					0900					
1000					1000					
1100					1100					
1200					1200					
1300					1300					
1400					1400					
8° TOTAL					8° TOTAL					SHIFT 1 NURSE
1500					1500					
1600					1600					
1700					1700					
1800					1800					
1900					1900					
2000					2000					
2100					2100					
2200					2200					
8° TOTAL					8° TOTAL					SHIFT 2 NURSE
2300					2300					
2400					2400					
0100					0100					
0200					0200					
0300					0300					
0400					0400					
0500					0500					
0600					0600					
8° TOTAL					8° TOTAL					SHIFT 3 NURSE
24° TOTAL					24° TOTAL					G.T. – Gastronomy N.G. – Nasogastric T.T. – T-Tube H.V. – Hemovac Ch.T. – Chest Tube VD – Void F – Foley IR – Irrigation
WEIGHT			PREV. TOTAL					PREV. TOTAL		

LEARNING ACTIVITIES - continued

Exercise 2. Estimating Liquids in cc's

Directions: Often when you remove the patient's tray you will find containers that are one half full or one quarter full. You must use your judgement to estimate the amount the patient has consumed. This exercise will help you sharpen your estimating skills.

Fill a styrofoam water cup	-	1/2 full of water
		3/4 full of water
		1/4 full of water
Fill a milk carton	-	3/4 full of water
		1/2 full of water

Estimate the amounts in each container to amounts in cc's. Now, measure each actual amount using a measuring container and see how close you came to being correct. Repeat this exercise until you come to within 15 to 20 cc's of being correct and accurate.

Exercise 3. Computing the Intake

Directions: From this situation below, compute the intake for this patient and record it on the "I & O" sheet provided on the next page. Then show the completed form to your instructor. If you have any problems computing the intake or recording the intake on this form, please tell your instructor.

Situation

Mrs. "D" is on a liquid diet since she has been very nauseated and vomiting frequently. At breakfast, she had a soup bowl of chicken broth but only ate about half of it. She ate all of her jello and drank three-fourths of her hot tea. Later at 10:30 a.m., she asked for a 7-Up and a styrofoam cup. For lunch, at 12:00 noon, she ate beef broth brought to her in a soup bowl and asked for more. She drank about half of the additional broth brought in a styrofoam cup. She also had two bowls of jello and a glass of apple juice.

Now, add up the TOTAL INTAKE for the eight hours you took care of her.

LEARNING ACTIVITIES - continued

Intake Record Sheet for Mrs. "D".

SAMPLE
INTAKE AND OUTPUT SHEET

INTAKE **OUTPUT** From 0600 Date ______________ To 0600 Date ______________

TIME	PO				TIME	URINE	STOOL			OUTPUT TESTS
0700					0700					
0800					0800					
0900					0900					
1000					1000					
1100					1100					
1200					1200					
1300					1300					
1400					1400					
8° TOTAL					8° TOTAL					SHIFT 1 NURSE
1500					1500					
1600					1600					
1700					1700					
1800					1800					
1900					1900					
2000					2000					
2100					2100					
2200					2200					
8° TOTAL					8° TOTAL					SHIFT 2 NURSE
2300					2300					
2400					2400					
0100					0100					
0200					0200					
0300					0300					
0400					0400					
0500					0500					
0600					0600					
8° TOTAL					8° TOTAL					SHIFT 3 NURSE
24° TOTAL					24° TOTAL					G.T. – Gastronomy N.G. – Nasogastric T.T. – T-Tube H.V. – Hemovac Ch.T. – Chest Tube VD – Void F – Foley IR – Irrigation
WEIGHT			PREV. TOTAL					PREV. TOTAL		

LEARNING ACTIVITIES - continued

Procedure for Measuring Output

Directions: Read the following procedure. When you demonstrate the procedure, your instructor will check off the steps as you accomplish them.

PROCEDURE: MEASURING OUTPUT	DEMONSTRATION/COMMENTS
1. Explain to your patient that his output is being measured and that all of the urine must be saved. Ask him to call you each time he voids so that you can measure the urine. If he is vomiting, ask him to vomit in the emesis basin and not to go to the toilet. Also, if your patient has liquid diarrhea, his stools must be saved and also measured.	1. ____________________
2. Collect any liquid output in a urinal, bedpan, or emesis basin and take it to the patient's bathroom. Remember, liquid output may include any of the following: urine, emesis, liquid diarrhea stool, drainage from tubes inserted into the patient's body.	2. ____________________
3. Pour the specimen into a measuring container which is marked in cc's or oz. Place the measuring container on a level surface at eye level and measure the amount of liquid output obtained. Immediately, record the amount in cc's under the output column on the "Intake and Output" record.	3. ____________________
4. Empty liquid output into the toilet and clean the measuring container and the collecting container (urinal, bedpan, emesis basin) with cold water.	4. ____________________
5. At the end of your 8-hour shift, add up the total outputs separately and mark each in the boxes labeled "8 Hr. TOTAL".	5. ____________________

LEARNING ACTIVITIES - continued

Exercise 5. Measuring Intake and Output

Directions: From the situations below, compute the intake and the output and record the amounts on the "I & O" sheets provided on the following pages. Add the total intake and the total output for the 8-hour shift. After you have recorded the "I & O" for both Mr. B and Mr. F, show your work to your instructor.

Situation #1: Mr. Bray is two days post-op from abdominal surgery. He has a tube which passes through his nose down into his stomach and is connected to Gomco suction. He is allowed to take ice chips and by 1500 (3:00 p.m.) he has had three water glasses of ice chips. He still has a Foley catheter draining his bladder and has IV's running slowly. At the end of the eight hours, his catheter bag was emptied and had 800 cc's of urine. His Gomco was emptied and contained 700 cc's. What was his intake and output for the eight hours?

Situation #2: Mr. Federico is now on a soft diet following heart surgery a week ago. His Foley has just been removed and he is voiding in small amounts frequently. At breakfast, he had a carton of milk with part of the milk poured over a bowl of hot cereal, a cup of coffee with cream, and toast. At lunch, he drank half of his carton of milk and drank a cup of tea. He ate a soft boiled egg and mashed potatoes. He had one container of ice cream for dessert. Each time his urinal was emptied, it was measured. The amounts measured were: 100 cc, 60 cc, 90 cc, 100 cc, 120 cc, 110 cc. At the end of the shift, half of his water pitcher was empty. At 1300 (1:00), Mr. "F" became nauseated and vomited 200 cc's. What was his intake and output for the 8-hour shift?

NOTE: Your instructor may wish to supply you with an I & O sheet from your local hospital for this activity.

LEARNING ACTIVITIES - continued

Situation #1: I & O Sheet for Mr. Bray

SAMPLE
INTAKE AND OUTPUT SHEET

INTAKE **OUTPUT** From 0600 Date ______ To 0600 Date ______

TIME	PO				TIME	URINE	STOOL			OUTPUT TESTS
0700					0700					
0800					0800					
0900					0900					
1000					1000					
1100					1100					
1200					1200					
1300					1300					
1400					1400					
8° TOTAL					8° TOTAL					SHIFT 1 NURSE
1500					1500					
1600					1600					
1700					1700					
1800					1800					
1900					1900					
2000					2000					
2100					2100					
2200					2200					
8° TOTAL					8° TOTAL					SHIFT 2 NURSE
2300					2300					
2400					2400					
0100					0100					
0200					0200					
0300					0300					
0400					0400					
0500					0500					
0600					0600					
8° TOTAL					8° TOTAL					SHIFT 3 NURSE
24° TOTAL					24° TOTAL					
WEIGHT			PREV. TOTAL					PREV. TOTAL		

G.T. – Gastronomy
N.G. – Nasogastric
T.T. – T-Tube
H.V. – Hemovac
Ch.T. – Chest Tube
VD – Void
F – Foley
IR – Irrigation

LEARNING ACTIVITIES - continued

Situation #2: I & O Sheet for Mr. Federico

SAMPLE
INTAKE AND OUTPUT SHEET

INTAKE **OUTPUT** From 0600 Date ______________ To 0600 Date ______________

TIME	PO				TIME	URINE	STOOL			OUTPUT TESTS
0700					0700					
0800					0800					
0900					0900					
1000					1000					
1100					1100					
1200					1200					
1300					1300					
1400					1400					
8° TOTAL					8° TOTAL					SHIFT 1 NURSE
1500					1500					
1600					1600					
1700					1700					
1800					1800					
1900					1900					
2000					2000					
2100					2100					
2200					2200					
8° TOTAL					8° TOTAL					SHIFT 2 NURSE
2300					2300					
2400					2400					
0100					0100					
0200					0200					
0300					0300					
0400					0400					
0500					0500					
0600					0600					
8° TOTAL					8° TOTAL					SHIFT 3 NURSE
24° TOTAL					24° TOTAL					
WEIGHT			PREV. TOTAL					PREV. TOTAL		

G.T. – Gastronomy
N.G. – Nasogastric
T.T. – T-Tube
H.V. – Hemovac
Ch.T. – Chest Tube
VD – Void
F – Foley
IR – Irrigation

LEARNING ACTIVITIES - concluded

ACTIVITY #2. Forcing Fluids

Directions: Read this material and the procedure that follows.

You will be instructed when a patient needs to be encouraged to drink more fluids. Some of the reasons for a patient needing more fluids added to the normal intake include:

1. the patient is unable to eat solid food
2. the patient has diarrhea
3. the patient has a fever
4. the patient has a bladder infection and needs to flush out his bladder
5. the patient is taking certain drugs

Procedure for Forcing Fluids

PROCEDURE: FORCING FLUIDS	DEMONSTRATION/COMMENTS
1. Explain to your patient that she needs to start drinking more fluids than she usually does.	1. ____________________
2. Ask your patient what fluids she likes best.	2. ____________________
3. Every thirty minutes to one hour, bring the patient a glass of fluid and encourage her to drink it all. The patient must take at least 800-1000 cc's during the 8-hours you are caring for her.	3. ____________________
4. Record the amount taken in cc's under the intake column on the "I & O" sheet.	4. ____________________

Exercise

Directions: List nine foods which are fluids. Answers can be found on page 3 of this module.

1. ________________
2. ________________
3. ________________
4. ________________
5. ________________
6. ________________
7. ________________
8. ________________
9. ________________

NURSING ASSISTANT SKILLS

Module B1 - Body Mechanics

RATIONALE

During your work as a nursing assistant, you will be doing many procedures that require muscular exertion. If you use these muscles continuously over a long period of time, they become tired and sore. You feel "worn out." By using correct body mechanics, this strain on your muscles will be decreased. You will have more energy and strength; you will feel better at the end of the day.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

Demonstrate safe body mechanics by lifting or moving any given object or patient.

LEARNING ACTIVITIES

Directions: All the information you will need to complete this part of Module B is included. Read the information and do the exercises. Remember, if you have any questions, STOP, and ask your instructor to help you.

ACTIVITY #1. Body Mechanics Terminology

Directions: Learn the definition for each of the following vocabulary words.

1. Body Mechanics: The way the body functions while you are standing, moving, and doing any job requiring physical effort. (The use of correct body mechanics helps to prevent injury to your body.)

2. Pivot: To turn the body by moving the feet rather than by twisting at the waist or hips.

3. Squat: To move closer to the floor from a standing position by bending the knees and hips and keeping the back straight.

4. Flex: To bend.

Exercise

Directions: Define each of the following terms in your own words. Check your answers with the preceding information.

1. Body Mechanics: ______________________________

____

____

LEARNING ACTIVITIES - continued

2. Pivot: ____

____

____

3. Squat: ____

____

____

4. Flex: ____

____

____

ACTIVITY #2. Using Correct Body Mechanics

Directions: Read the following material.

Tell your patient what you plan on doing, let her know how you plan to do it, and how she can help. Encourage your patient to do as much as she can for herself.

Get help. Waiting for help is far less inconvenient than a strained back!! Do not move equipment or a patient if the load is more than you can handle alone.

Below are some key points about body mechanics for you to read and to practice continuously.

1. Do not lift anything or anyone if you can push or pull it. Move your patient by rolling or turning rather than by lifting, whenever possible.
2. Watch you feet. When lifting or moving equipment, your feet should be apart. You will be better balanced and more stable.
3. Move close to what you want to move or lift. Do not reach. You will strain arm and shoulder muscles by reaching.
4. Hold objects close. Keep elbows relaxed and hold the objects close to the pelvic region of your body.
5. Squat. When working close to the floor, keep your back straight, and bend your knees and your hips. Let your legs do the work, not your back.
6. Lift by straightening your legs. Use the big, strong muscles in your legs, not the weak muscles in your back.
7. Pivot. Do not twist. Move your feet to turn, do not twist at the waist or hips.

LEARNING ACTIVITIES - concluded

8. Be smooth. Avoid jerky movements. Once you start to move, keep on going. Do not STOP and start again. If a person is helping you, move together. It is a good idea to count, "1 - 2 - 3"!!

9. Always size up your load. Get help if needed.

Exercise. Demonstrate Body Mechanics

Directions: Now demonstrate to your instructor the use of correct body mechanics as you:

1. Carry a pillowcase full of dirty laundry to the dirty laundry room.
2. Lift a box of books off the floor and place them on a table.
3. Roll up the head of the bed.
4. Move a heavy bookcase from one part of the room to another part.

REMEMBER: When you finish Modules B2, B3, and B4, your instructor will also be watching your demonstrations to be sure you use correct body mechanics.

NURSING ASSISTANT SKILLS

Module B2 - Correct Procedure to Move and Lift the Patient

RATIONALE

As you work in a health care facility, you will find that it is often necessary for the nursing assistant to move a patient from one position to another. At times, this must be done with little or no help from the patient. To prevent injury to yourself and to provide for the safety and comfort of your patient, you must apply the principles of correct body mechanics when lifing or moving your patient.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Turn the patient on his/her side.
2. Logroll the patient who has had back surgery or back injury.
3. Help the patient move up in bed.
4. Move the helpless patient up in bed.
5. Help the patient move to a sitting position with feet dangling.
6. Help the patient with abdominal surgery move to a dangling position.
7. Transfer the patient from a bed to the wheelchair.
8. Assist the patient out of bed to ambulate.

LEARNING ACTIVITIES

Directions: In this part of Module B, you will view a Trainex and be asked to demonstrate procedures. The part of the procedure labeled DEMONSTRATION/COMMENTS is for your instructor to use to make comments while you demonstrate the steps of each procedure. You have eight different procedures to demonstrate, so GET BUSY!!!

LEARNING ACTIVITIES - continued

ACTIVITY #1. Moving and Lifting the Patient

Directions: View the Trainex Moving and Lifting the Patient. Read the following procedures. When you demonstrate this procedure, your instructor will make comments on the steps as you accomplish them.

Procedure for Turning the Patient on the Side

PROCEDURE: TURNING THE PATIENT ON THE SIDE	DEMONSTRATION/COMMENTS
1. Lower the side rails and stand close to the bed on the side where you will move the patient.	1. __________
2. Move the patient's shoulders towards you.	2. __________
3. Move the patient's hips towards you.	3. __________
4. Have the patient flex her knees or cross one ankle over the other.	4. __________
5. Place the patient's arm closest to you across her chest and the other arm along the side of her head.	5. __________
6. Roll the patient to her side.	6. __________
7. Position the pillow to the back and between her knees.	7. __________

Procedure for Logrolling the Patient

PROCEDURE: LOGROLLING THE PATIENT WHO HAS HAD BACK SURGERY OR INJURY	DEMONSTRATION/COMMENTS
1. Ask someone to help you. Remove all pillows.	1. __________
2. Place the turning sheet under the patient from the head to below the knees.	2. __________

LEARNING ACTIVITIES - continued

PROCEDURE: LOGROLLING THE PATIENT WHO HAS HAD BACK SURGERY OR INJURY	DEMONSTRATION/COMMENTS
3. Place the pillow between the knees.	3. ______________
4. Using the turning sheet, pull the patient to the opposite side of the bed.	4. ______________
5. Roll the edge of the turning sheet into a tight roll close to the patient's body.	5. ______________
6. Count, "1 - 2 - 3" and roll the patient on his side. Work together. Make sure the patient's head and chest turns at the same time so that the hips and legs turn.	6. ______________
7. Position the pillow to the back.	7. ______________

Procedure for Helping the Patient Move Up in Bed

PROCEDURE: HELPING THE PATIENT MOVE UP IN BED	DEMONSTRATION/COMMENTS
1. Remove the pillow and lower the head of the bed.	1. ______________
2. Have the patient bend the knees and push with the feet when you are ready to move.	2. ______________
3. Place your arm under the patient's shoulders and the other arm under the armpit closest to you with your hand behind the shoulders.	3. ______________
4. Count, "1 - 2 - 3" and work with the patient to move her up to the head of the bed.	4. ______________

LEARNING ACTIVITIES - continued

Procedure for Moving the Helpless Patient Up in Bed

PROCEDURE: MOVING THE HELPLESS PATIENT UP IN BED	DEMONSTRATION/COMMENTS
1. Ask someone to help you. Remove the pillow and lower the head of the bed.	1. ______________________
2. Place the turning sheet or drawsheet under the patient.	2. ______________________
3. Roll the edges of the turning sheet into a tight roll close to the patient's body.	3. ______________________
4. Count, "1 - 2 - 3" and move the patient towards the head of the bed.	4. ______________________

Procedure for Helping the Patient Move to a Sitting Position with Feet Dangling

PROCEDURE: HELPING THE PATIENT MOVE TO A SITTING POSITION WITH FEET DANGLING	DEMONSTRATION/COMMENTS
1. Lower the bed to its lowest level. Raise the head of the bed to a sitting position.	1. ______________________
2. Support the patient's shoulder with one hand. Place your other arm under her knees to help her swing her legs over the edge of the bed.	2. ______________________
3. Observe your patient. Put her back in a lying position and notify the nurse in charge if the patient: a. becomes very pale b. perspires a lot c. has a fast pulse d. complains of feeling very weak, dizzy, or faint.	3. ______________________

LEARNING ACTIVITIES - continued

Procedure for Helping the Patient with Abdominal Surgery Move to a Dangling Position

PROCEDURE: HELPING THE PATIENT WITH ABDOMINAL SURGERY MOVE TO A DANGLING POSITION	DEMONSTRATION/COMMENTS
1. Lower the bed to its lowest level. Raise the head of the bed to a sitting position.	1. ______________________
2. Ask your patient to turn on his side facing you. In this position, he will use his side muscles to move to a dangling position instead of his abdominal muscles.	2. ______________________
3. Have the patient place his arm under your armpit with his hand on your shoulder. Place your arm under his shoulders.	3. ______________________
4. Instruct the patient to slowly move his legs over the edge of the bed by using the side rails as steps. Help guide his legs with your free hand.	4. ______________________
5. Observe your patient as he dangles. List the four observations you will be careful to watch for: a. ______________________ b. ______________________ c. ______________________ d. ______________________ What do you do if you see any of these four observations while your patient is dangling?	5. ______________________

LEARNING ACTIVITIES - continued

Procedure for Transferring the Patient from a Bed to the Wheelchair

PROCEDURE: TRANSFERRING THE PATIENT FROM A BED TO THE WHEELCHAIR	DEMONSTRATION/COMMENTS
1. Place the chair in a position with the back near the foot of the bed. Place a blanket in the wheelchair. Adjust the footrests so that they are turned up. Set the brakes on the wheelchair.	1. ____________________
2. Lower the bed to its lowest level. Raise the head of the bed to a sitting position and dangle the patient.	2. ____________________
3. Observe your patient while you put on her robe and slippers.	3. ____________________
4. Stand in front of the patient and assist her to a standing position.	4. ____________________
5. Pivot or turn with the patient so that she is in position to sit in the chair.	5. ____________________
6. Lower the patient into the wheelchair. Adjust the footrests and fasten the seat belt.	6. ____________________

Procedure for Assisting the Patient Out of Bed to Ambulate

PROCEDURE: ASSISTING THE PATIENT OUT OF BED TO AMBULATE	DEMONSTRATION/COMMENTS
1. Lower the bed to its lowest level. Raise the head of the bed to a sitting position and dangle the patient.	1. ____________________
2. Observe your patient. Put his robe and slippers on.	2. ____________________
3. Stand in front of the patient and assist him to a standing position.	3. ____________________

LEARNING ACTIVITIES - concluded

PROCEDURE: ASSISTING THE PATIENT OUT OF BED TO AMBULATE	DEMONSTRATION/COMMENTS
4. Allow the patient to stand and to shift his weight from foot to foot to help maintain balance.	4. ____________
5. Place one hand under the patient's elbow and the other arm around the waist.	5. ____________
6. Assist him to walk. Make sure he is standing straight with his head up.	6. ____________

Exercise

Directions: Now, take the DEMONSTRATION/COMMENTS section in your module to your instructor. Ask another student to be your patient and demonstrate to your instructor:

1. Turning the patient on his side
2. Logrolling the patient who has had back surgery or injury
3. Helping the patient move up in bed
4. Moving the helpless patient up in bed
5. Helping the patient move to a sitting position with feet dangling and transferring him to the wheelchair
6. Helping the patient with abdominal surgery move to a dangling position and assisting him to ambulate.

NURSING ASSISTANT SKILLS

Module B3 - Various Positions for the Bedridden Patient

RATIONALE

Did you know that you move or shift positions at least every thirty seconds while you are awake and at least every ten minutes in your sleep? Your body tells you when it is time to move. It will not allow you to stay in one position for long. Some very sick patients or patients with pain do not want to change their position and will need your encouragement to help them move. Helpless or unconscious patients depend on you to change their positions for them.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate positioning the patient in the following positions:

   a. Supine
   b. Side-lying
   c. Prone
   d. Fowler's
   e. Orthopneic
   f. Trendelenberg
   g. Sim's
   h. Lithotomy
   i. Knee-Chest

2. Identify the positioning required for specific conditions, treatments, and examinations.

3. Demonstrate the use of the footboard, handroll, trochanter roll, bed cradle, and bedboard.

LEARNING ACTIVITIES

Directions: You have lots of information to read and to learn in this part of Module B. You will be asked to demonstrate each position so READ CAREFULLY. Be sure to view the Trainex and answer all of the questions. Remember, your instructor is there to help you.

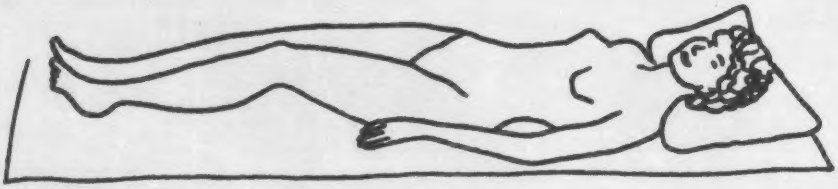
ACTIVITY #1. Positions of Patients in Bed

Directions: Read the following information.

Patients must be placed in positions of proper alignment to best facilitate recovery and to prevent the development of complications or deformities. A helpless or unconscious patient should have his position changed at least every two hours. There are four basic positions for the patient in bed: supine, side-lying, prone, and Fowler's.

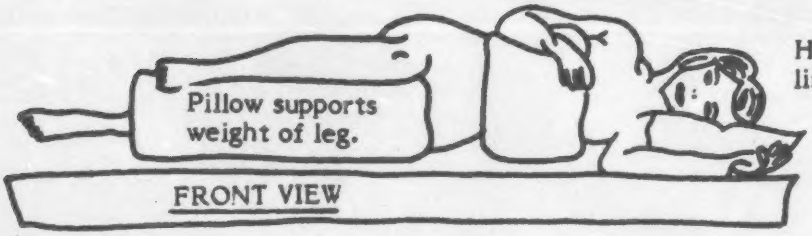
LEARNING ACTIVITIES - continued

SUPINE

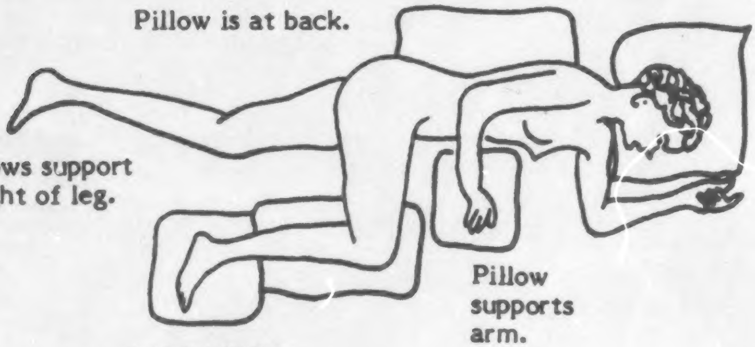


A small pillow supports the head. The head is aligned in a straight line with the spine. Arms are relaxed, rest at side of the body.

SIDE-LYING


Pillow supports arm and head.
Head is in straight line with spine.
Pillow supports weight of leg.

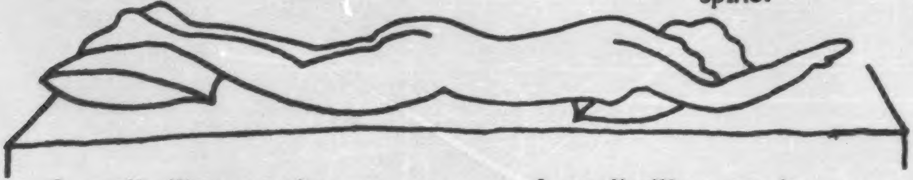
FRONT VIEW


Pillow is at back.
Head is in straight line with spine.
Pillows support weight of leg.
Pillow supports arm.

TOP VIEW

LEARNING ACTIVITIES - continued

PRONE

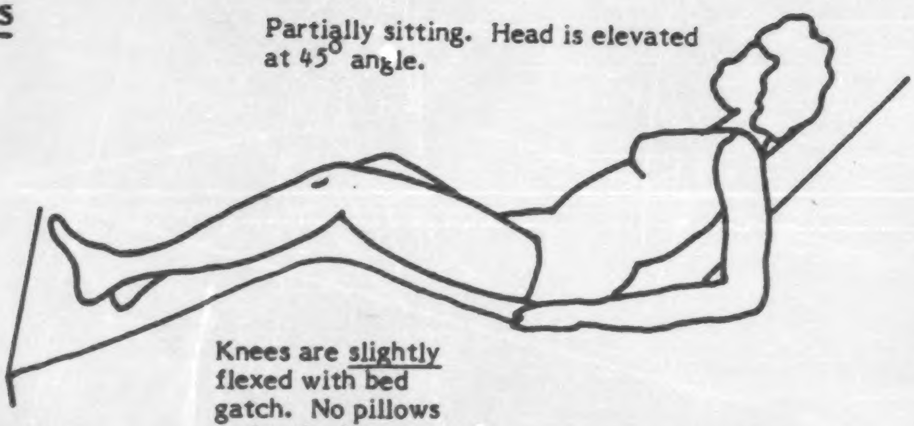


Head resting on mattress relieves strain on the spine.

A small pillow may be placed under the legs to relax the muscles.

A small pillow may be placed under the chest to relieve pressure on the breasts.

FOWLER'S



Partially sitting. Head is elevated at 45° angle.

Knees are slightly flexed with bed gatch. No pillows under the knees.

Of all the positions ordered for a patient, the most common as well as the most difficult to maintain is the Fowler's position. In Fowler's position, the patient will always slip down in the course of time and frequent lifting up in bed and readjustment of the pillows will be necessary.

Fowler's position is:

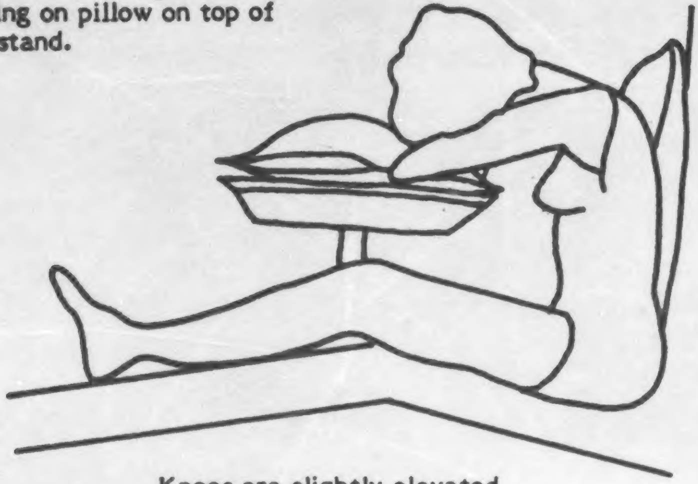
1. a comfortable sitting position
2. the bed position prior to dangling
3. frequently ordered for patients with dyspnea

LEARNING ACTIVITIES - continued

ORTHOPNEIC

Head of the bed elevated to 90° angle.

Patient is leaning forward while resting on pillow on top of bed stand.



Knees are slightly elevated.

The patient's physical condition or injury may require the she be placed in a certain position. Also, physicians may ask that patients be placed in a special position for treatments or examinations. Shown above and on the following pages are some of the positions that are most commonly ordered.

Because the patient in the orthopneic position is sitting straight in bed, the thoracic cavity may more fully expand allowing the lungs to fill with more air when the patient inhales. The contracting diaphragm does not meet resistance from abdominal organs pushing up against it. Also, the patient is leaning forward so that her back is not splinted by the bed. Again, the patient is able to deep breathe much easier. Try breathing in this position yourself and see if you notice a difference in your breathing.

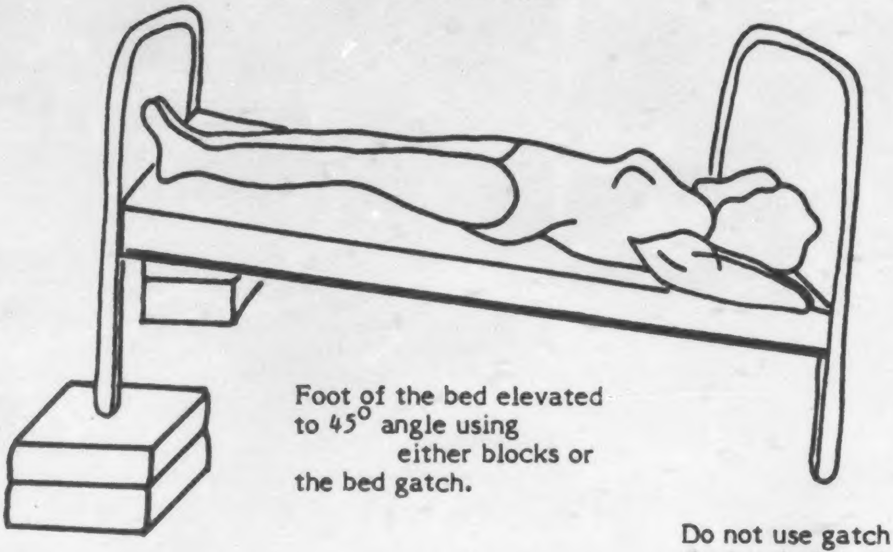
Orthopneic position is frequently ordered for:

1. patients with cardiac conditions that result in dyspnea
2. patients with respiratory conditions
3. any patient in respiratory distress

LEARNING ACTIVITIES - continued

TRENDELENBERG

Patient lying on back. Body is on an inclined plane with head and shoulders lower than hips and legs.



Foot of the bed elevated to 45° angle using either blocks or the bed gatch.

Do not use gatch to raise the head of the bed or to bend the knees.

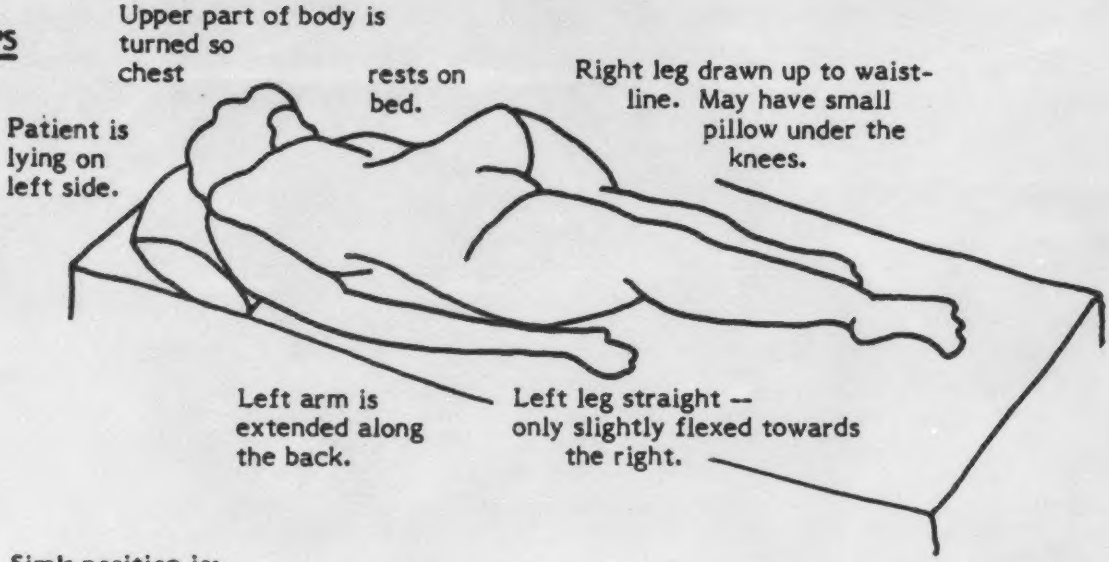
Trendelenberg's position is also called the "shock" position. The position helps to increase the blood flow to the brain. This position should not be used if the patient has any respiratory difficulties or if he has had a head injury.

Trendelenberg's position is used:

1. when patients are in shock or have a decreased blood pressure
2. for some patients after operative procedures on pelvic organs.

LEARNING ACTIVITIES - continued

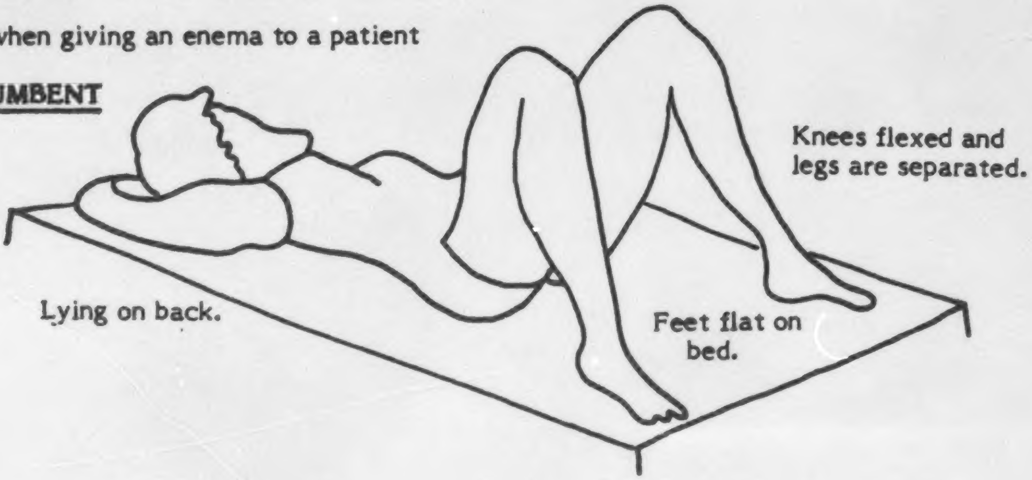
SIM'S


Upper part of body is turned so chest rests on bed.
Patient is lying on left side.
Right leg drawn up to waistline. May have small pillow under the knees.
Left arm is extended along the back.
Left leg straight — only slightly flexed towards the right.

Sim's position is:

1. a comfortable position for sleeping especially if the patient is pregnant
2. used for vaginal and rectal examinations
3. used when giving an enema to a patient

DORSAL RECUMBENT

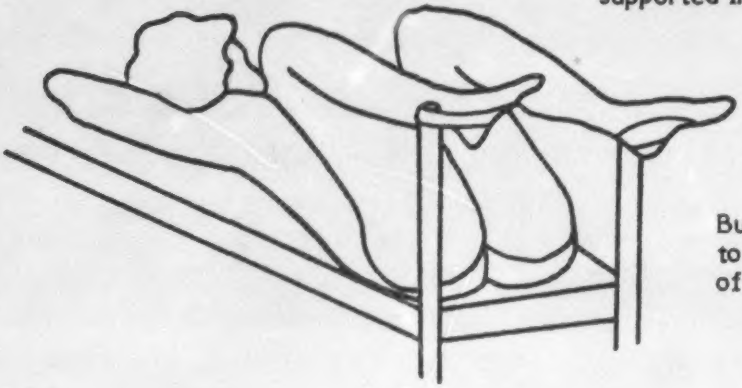

Knees flexed and legs are separated.
Lying on back.
Feet flat on bed.

The dorsal recumbent position is very useful for many examinations and treatments. It is used for:

1. pelvic examinations
2. digital examinations of rectum
3. catheterization
4. giving perineal care or vaginal douches

LEARNING ACTIVITIES - continued

LITHOTOMY



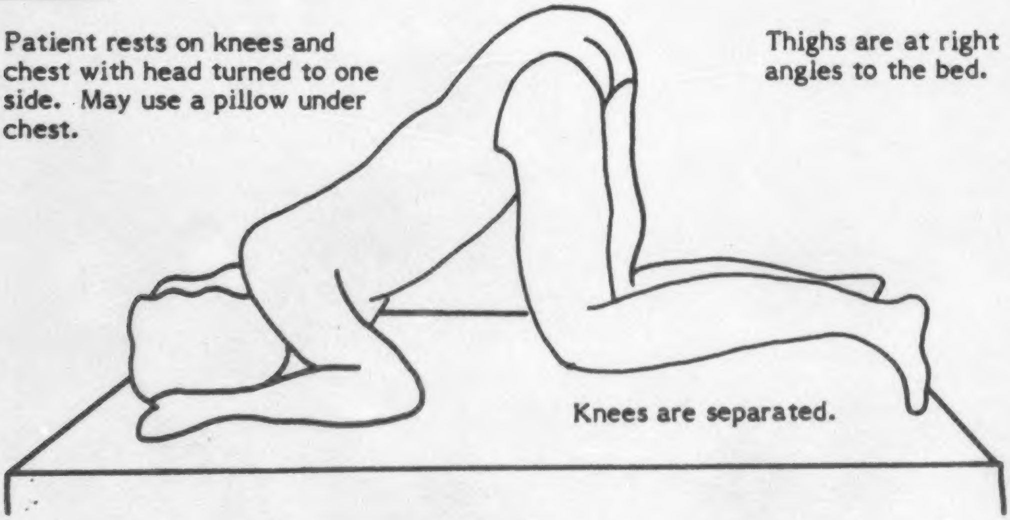
Legs are well separated.

Thighs flexed on abdomen with legs supported in stirrups.

Buttocks are moved to the very edge of the table.

The lithotomy position is used for examinations of the: (1) perineum, (2) vagina for PAP smears, (3) cervix for PAP smears, (4) bladder, and, (5) rectum.

KNEE-CHEST



Patient rests on knees and chest with head turned to one side. May use a pillow under chest.

Thighs are at right angles to the bed.

Knees are separated.

The knee-chest position is used for (1) proctoscopic examination of the rectum and lower colon, and (2) as a postpartum exercise to help the uterus return to its normal position after delivery.

LEARNING ACTIVITIES - continued

Exercise 1.

Directions: Answer these questions by filling in the blanks or by circling the correct answer. Answers to these questions can be found on page 11.

1. How often must a helpless or unconscious patient be repositioned?

   ____

2. In supine position, the patient lies face down with a pillow under the chest and ankles. TRUE FALSE

3. In Fowler's position, the head is elevated at a (45°, 90°) angle and the knees are (not flexed, slightly flexed).

4. Orthopneic position is ordered for patients with ______________________.

5. Trendelenberg's position is also called the ______________ position because it is used for patients in ______________.

6. The position used when giving a patient an enema is ________________ position.

7. In Sim's position, the patient is placed on his ________________ side.

8. The lithotomy position is used for examinations of the __________________.

9. If a doctor orders that a patient be set up for a proctoscopic examination, you know to place the patient in a ________________ position.

Exercise 2.

Directions: View the Trainex Positioning to Prevent Contractures. After listening to the Trainex, answer the following questions by filling in the blanks or by circling the correct answer. Answers can be found on page 11 of this module.

1. In the supine position, the patient is lying on her __________________.

2. Two pillows may be placed under the patient's head to keep him in the correct supine position. TRUE FALSE

3. To extend the wrist in a functional position and to prevent contractures of the wrist and the fingers, a ______________ may be positioned in the patient's hand.

4. A ______________ may be used to keep a leg from externally rotating.

5. Pillows may be placed under the patient's knees whenever he asks.
   TRUE FALSE

6. The footboard helps to prevent a deformity of the ankle known as ______________________.

LEARNING ACTIVITIES - continued

7. Describe two ways to keep pressure off the heels when the feet are placed against the footboard.

   a. ______________________________

   b. ______________________________

8. When a patient is placed on her abdomen, she is in the ______________ position.

9. In the prone position, the feet should extend over the edge of the mattress or a small pillow may be placed under the ankles to keep the toes off the mattress.
   TRUE FALSE

10. A patient in the side-lying position tends to curl up and may easily develop contractures if not properly supported with pillows. TRUE FALSE

11. To prevent contractures you must:

    a. ______________________________

    b. ______________________________

ACTIVITY #2. Devices Used for Proper Body Positioning

Directions: Read the following information.

There are many devices used to make sure that a patient remains in a correct body position. These devices not only help maintain normal anatomical position, but also give support and add to the patient's comfort and feeling of well-being. Some devices are discussed below.

FOOTBOARD

The footboard or footrest is a board placed between the mattress and the foot of the bed. The feet should be positioned flat against the board at right angles to the legs as in a natural standing position. The board should extend above the toes to provide support to the entire foot. Make sure that the heels are free from pressure by seeing that they rest in the space between the footboard and the end of the mattress. If there is no space, elevate the heels by placing a rolled towel under the ankles. The footboard helps to prevent a deformity of the ankle known as footdrop. In footdrop, the foot becomes permanently hyperextended so that the patient is unable to walk on the flat of her foot.

HANDROLL

To keep the fingers in a normal position for grasping or for holding, a handroll may be necessary. Make a handroll by rolling two washcloths together and taping them. Place the roll in the palm of the patient's hand with the fingers around the top and the thumb holding it underneath.

LEARNING ACTIVITIES - concluded

TROCHANTER ROLL

If the patient has a paralyzed leg, the leg may roll out at the hip joint (externally rotate). A trochanter roll should be used to hold the leg in correct position. You may make a trochanter roll using a sheet or a bath blanket. Fold the blanket in half - the narrow way. Place the folded side of the blanket under the involved leg. Underroll the other end firmly against the body by tucking it under itself to secure it in place.

BED CRADLE

The bed cradle is a frame placed over the bed, the ends of which are secured under the mattress on both sides of the bed. It is used to prevent the sheets, blankets, and bedspreads from falling on or coming in contact with some part of the patient's body. Bed cradles are frequently ordered to protect fractured limbs, burns, or open lesions or just to keep weight off the patient's toes.

BEDBOARDS

Bedboards are boards placed under the mattress on the springs of the bed to give a more firm support.

Exercise.

Directions: Choose another student to be your patient and demonstrate to your instructor the position for each of the following positions:

1. Supine
2. Side-Lying
3. Prone
4. Fowler's
5. Orthopneic
6. Trendelenberg
7. Sim's
8. Dorsal Recumbent
9. Lithotomy
10. Knee-Chest

Still using this student as your patient, correctly position her feet against a footboard and make and correctly position:

1. a handroll
2. a trochanter roll

ANSWERS

ACTIVITY #1

Exercise 1

1. every two hours
2. FALSE
3. 45°, slightly flexed
4. respiratory distress
5. "shock", shock
6. Sim's
7. left
8. perineum, vagina, cervix, bladder, rectum
9. knee-chest

Exercise 2

1. back
2. FALSE
3. handroll
4. Trochanter roll
5. FALSE
6. footdrop
7. a. Rest the heels in the space between the mattress and the footboard.
   b. Elevate the heels by placing a rolled towel under the ankles.
8. prone
9. TRUE
10. TRUE
11. a. Position the patient properly.
    b. Change the position frequently.

NURSING ASSISTANT SKILLS

Module B4 - Range of Motion Exercises

RATIONALE

As a member of the nursing staff, you may be asked to do range of motion exercises on patients unable to move themselves.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate and answer written questions relating to the normal range of motion for each joint.
2. Identify joints susceptible to the development of contractures.

LEARNING ACTIVITIES

Directions: Read the information provided in this part of Module B and answer the questions. The Trainex, Range of Motion Joint Exercise, helps to make the information more clear. So, be sure to view it.

ACTIVITY #1. Range of Motion

Directions: Read this information.

Range of motion refers to the extent of motion within a joint. Below is a chart which shows you the types of joints found in the human body and the type of movement each joint is capable of doing.

JOINT	NORMAL MOVEMENT
BALL AND SOCKET:	
Shoulder Hip (Both of these joints are capable of the same movements)	Flexion Extension Abduction Adduction Internal Rotation External Rotation Hyperextension
HINGE:	
Elbow	Flexion Extension
Knee	Flexion Extension

LEARNING ACTIVITIES - continued

JOINT	NORMAL MOVEMENT
GLIDING:	
Wrist	Extension Flexion Ulmar Deviation Radial Deviation
Ankle	Dorsiflexion Plantarflexion Eversion Inversion
FINGERS AND TOES:	Flexion Extension Abduction Adduction
PIVOT:	
Neck	Flexion Extension Rotation Hyperextension

Each joint has muscles which contract or shorten and relax or lengthen to allow for movement. For example, when one muscle is contracted, the joint is flexed. When this muscle is relaxed, a second muscle contracts to move the joint back into extension. If a joint is immobilized and allowed to remain flexed for a long period of time, the joint will become stiff. The muscle which is flexing the joint becomes short and thickens and will not relax to allow the joint to extend. The other muscle becomes stretched and is too weak to pull the joint back into extension. This deformity is known as a contracture.

Joints which are most commonly deformed by contractures include: hip, shoulder, wrist and hand, knee, and ankle (foot drop).

These deformities greatly hinder the person's ability to perform the activities of daily living (ADL). They are often painful and are unattractive.

Remember, contractures develop in joints that are immobile. Consequently, contractures are most likely to occur following fractures, amputations, paralysis, and in patients who are unconscious, burned, or inactive because of age.

Contractures are easily prevented. However, once they develop, a contracture will take years of diligent physical therapy to correct. The preventing of contractures is a nursing responsibility. If a patient develops a contracture, the nurse may have been negligent.

LEARNING ACTIVITIES - continued

Contractures may be prevented by:

1. positioning the patient properly (see Module B3 "Positioning the Patient in Bed")
2. changing position frequently - at least every two hours
3. doing range of motion exercises at least four times a day
4. starting early and being consistent in nursing care activities

Exercise. Range of Joint Motion Exercises

Directions: View the Trainex, Range of Joint Motion Exercises. After watching the Trainex, answer the following questions by filling in the blanks or by circling the correct answer. Answers can be found on page 6 of this module.

1. A contracture develops because one muscle is contracted holding the joint in flexion and the other muscle is too weak to pull the joint back into extension.
TRUE FALSE

2. List five joints that are most commonly deformed by contractures.

a. ____________________

b. ____________________

c. ____________________

d. ____________________

e. ____________________

3. List three types of patients most susceptible to the development of contractures.

a. ____________________

b. ____________________

c. ____________________

4. Ball and socket joints include the __________ and __________.

5. Ball and socket joints are capable of seven different ranges of motion. List the seven.

a. ____________________

b. ____________________

c. ____________________

LEARNING ACTIVITIES - continued

d. ______________________________

e. ______________________________

f. ______________________________

g. ______________________________

6. An example of a hinge joint is the __________ or __________.

7. The normal movement a hinge joint is capable of includes __________ and __________.

8. What does ADL stand for? ______________________________

9. While doing range of motion exercises, work slowly and smoothly. Do not exercise the patient past the point of __________.

10. What is the difference between passive exercises and active exercises?

    Passive: ______________________________

    Active: ______________________________

11. As soon as the patient is able, she may exercise her shoulder by doing her own daily care activities such as ____________________.

12. To exercise the patient's wrist, support the patient's hand in your palm and __________ and __________ the wrist.

13. Flexion contractures of the wrist are very uncommon and the wrist only needs to be exercised occasionally. TRUE FALSE

14. It is a good idea to encourage the patient to exercise the fingers of her paralyzed hand with her good hand. TRUE FALSE

15. In performing range of motion exercises, the knee and __________ may be exercised together.

16. To internally rotate and externally rotate the hip, support the __________ joint and __________ joint and roll the hip outward and inward.

17. Pointing the foot upward is ______________ of the ankle and pointing the foot downward is plantar flexion.

In case you do not have access to the filmstrip, the answer key will be helpful as a study guide for this module.

LEARNING ACTIVITIES - concluded

ACTIVITY #2. Demonstrate What You Have Learned

Directions: Ask another student to be your patient and practice range of motion exercises on the following:

1. Neck
2. Shoulder
3. Elbow
4. Wrist
5. Fingers
6. Hip
7. Knee
8. Ankle
9. Toes

When you think you have learned how to do the exercises given above, demonstrate each for your instructor.

ANSWERS

ACTIVITY #1

1. TRUE
2. shoulders, wrist, fingers, hips, knees, ankles
3. unconscious, burn, inactive aged, following amputation, fractures, paralyzed
4. hip, shoulder
5. flexion, extension, hyperextension, abduction, adduction, internal rotation, external rotation
6. knee, elbow
7. flexion, extension
8. Activities of Daily Living
9. pain
10. passive - exercise performed by the nurse for the patient

    active - exercise performed by the patient without the help of the nurse
11. combing her hair
12. flex, hyperextend
13. FALSE
14. TRUE
15. hip
16. knee, ankle
17. dorsiflexion

NURSING ASSISTANT SKILLS

Module B5 - Care of the Patient in a Cast or in Traction

RATIONALE

In your work in a health care facility, you may be asked to take care of a patient in a body cast or one in cervical traction. If you read the information in this module, you will know what to do.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Recognize the signs of impaired circulation.
2. Identify and demonstrate the procedures for giving care to the patient in a cast.
3. Identify four types of skin tractions and two types of skeletal tractions.
4. Identify and demonstrate the procedure for giving care to the patient in skin and in skeletal traction.

LEARNING ACTIVITIES

Directions: You are almost finished with Module B. There is a lot of information to read to learn in this part, so GET BUSY!!! Remember to view the two Trainexes and answer all of the questions. Ask your instructor for help if you need it.

ACTIVITY #1. Care of the Orthopedic Patient

Directions: Read this material on care of the patient in a cast.

Patients with broken bones or fractures are usually in bed for long periods of time. They are generally immobile because of the weight of a cast on part of the body or because they are "hooked up" in traction.

Patients with fractures often must be absent from work or from school, or must be away from home for an extended time while the bones heal.

Children's bones usually heal more quickly, but older patients' bones heal more slowly.

The orthopedic patient is often sad and depressed because of this prolonged inactivity and because of the dependence on others. He may not talk too much or may cry very easily; or he may become "demanding" and push the call light on every fifteen minutes. In caring for these patients, you must show your concern and constant willingness to help. Visit the patient frequently, before he pushes the light on, and ask if he needs anything, or just spend a few minutes talking with him.

LEARNING ACTIVITIES - continued

While caring for an orthopedic patient, you must be very observant. Listen to ALL complaints of patients in casts or in traction. Check out possible causes of the complaint and report to the nurse in charge. Immediate action must be taken if the patient's complaint or your observations lead you to suspect impaired circulation in an extremity that is in a cast or in traction.

The signs of impaired circulation are:

1. swelling
2. unusual skin color as cyanosis, pale or blanched, or excessive redness
3. toes or fingers are unusually cold
4. inability to move fingers or toes
5. complaints of numbness, burning, or tingling pain
6. slow capillary refill on doing the "blanching" test

When checking an extremity for adequate circulation, you will feel the fingers or toes to check temperature. They should feel warm. Compare the temperature of the involved extremity with that of the uninvolved extremity. The temperature should be the same. At the same time, you can observe the color of the skin. The color of the involved extremity should be the same as the uninvolved extremity. A cyanotic or bluish discoloration may mean that the blood is pooling in the extremity and is unable to get back to the heart.

A pale white or blanched color may mean that pressure is not allowing the blood to reach the fingers or toes. Check the extremity for signs of swelling and again compare the involved with the uninvolved extremity. Pinch and release the fingernails or toenails -- watch for the immediate return of the blood. This test is known as the "blanching" test and it tells you how fast the patient's capillary blood returns. Ask your patient to wiggle his fingers or toes. Check with him to see if he has any complaints of numbness, burning or tingling pain. If you observe any of the signs indicating impaired circulation, notify the nurse in charge immediately. Not all of the signs need to be present for you to suspect the possibility of impaired circulation in a localized area.

Impaired circulation stops the supply of food and oxygen to the cells in the surrounding tissues. Cells die rapidly without food and oxygen, just as you do if you cannot eat or breathe.

This death of tissue called necrosis may eventually become gangrenous. Once gangrene develops, the tissue must usually be removed surgically. This could mean that a foot, or hand, or leg, or arm may need to be amputated or surgically removed. DO NOT be the cause of a needless amputation!!! Observe carefully!!!

LEARNING ACTIVITIES - continued

Exercise 1.

Directions: Define the following terms.

1. fracture: ______________________________
2. orthopedic: ______________________________
3. cyanotic: ______________________________
4. blanched: ______________________________
5. blanching test: ______________________________
6. necrosis: ______________________________
7. gangrene: ______________________________
8. amputation: ______________________________

Exercise 2.

Directions: Answer these questions by circling the correct answer or by filling in the blanks. Answers to this exercise can be found in the preceding information.

1. For the past three days you have been feeding Mr. Jones. One arm is in a cast and the other arm is immobilized for I.V. therapy. One morning when you bring him his breakfast tray he yells at you, "Just put it down and get out of here!! I'm no baby." What would you do?

    a. Make light of his comment. Laugh and tell him he certainly is acting like a baby now.

    b. Point out the facts. Remind him that his one arm is in a cast and if he moves his other arm, he will probably dislodge the I.V. needle.

    c. Take his tray and tell him you will bring it back when he feels better.

    d. Set up his tray so that everything is in easy reach. Butter his toast, open his milk carton and pour his milk, and season his egg. Recognize that he probably needs to be alone and come back in a few minutes.

2. List the six signs of impaired circulation.

    a. ______________________________

    b. ______________________________

    c. ______________________________

    d. ______________________________

LEARNING ACTIVITIES - continued

e. ____

f. ____

3. The blanching test helps measure ________________ blood ________________.

4. A patient has a cast applied for a fracture of his tibia and is now complaining of pain in his ankle area. You remember that this patient has a history of drug addiction and complained of pain in almost every bone before the cast was applied. You would:

   a. tell him that a little pain is to be expected until the cast drys completely.

   b. feel his toes for warmth, check the skin color and capillary refill, ask him to move his toes.

   c. tell your team leader.

   d. remind him that he had medication for pain one hour ago and it is too early for more.

   Which action would you take? Circle your answer below.

   a. All of the above

   b. "B" only

   c. "B" and "C"

   d. "D" only

5. When circulation is impaired, tissue cells die. This death of tissue is called ________________.

Exercise 3.

Directions: Ask another student to be your patient and pretend that his lower leg is in a cast. Demonstrate to your instructor how you would check the extremity for adequate circulation.

ACTIVITY #2. Care of the Patient in a Cast

Directions: Read the following information.

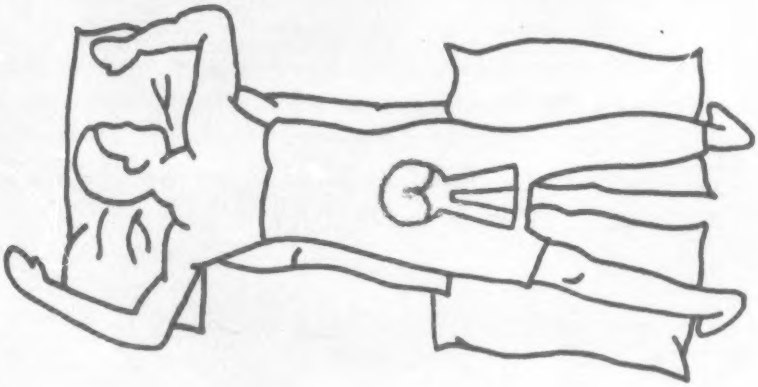
A cast is usually made of plaster-of-paris bandage and is applied to immobilize and to support a part of the body in the treatment of types of fractures, dislocations, joint disorders, and skeletal deformities. A roll of plaster-of-paris bandage is placed in warm water and is then applied by the physician to form the cast. This bandage hardens or sets as it dries. The area to be enclosed in a cast may first be padded with cotton or covered with a stockinette.

LEARNING ACTIVITIES - continued

There are two types of casts:

1. the extremity cast - one applied to an arm or leg to treat fractures or deformities of the femur, knee, tibia, fibula, radius, ulna, humerus.

2. the body cast or spica cast - used to treat fracture or dislocation of the lumbar spine, upper femur, or hip joint.



SPICA CAST

A cast may take several hours to several days to dry. A dry cast looks white and shiny; a wet cast is gray and dull. During the drying process, the cast needs to be well protected and the patient needs to be carefully observed.

Observations and/or procedures to be performed:

1. Expose the cast to air - do not cover it with blankets. If the patient is cold, he may be covered but not the cast.

2. Support the cast on pillows that have been protected by a rubber sheet or plastic. The damp cast should never be placed on a hard bed as it will flatten over bony prominences. Flattened areas press on tissue and can cause damage after the cast has dried. Placing the cast on pillows also elevates the fractured part which helps to prevent swelling or edema.

3. Handle the wet cast only with the palms of your hands instead of your fingers. Finger indentations may cause a pressure sore on the patient's skin after the cast has dried.

4. The patient in a spica cast should be turned over to insure thorough drying.

5. Check the circulation of the extremity enclosed in a cast at frequent intervals.

LEARNING ACTIVITIES - continued

As you care for the patient after the cast has dried, you must remember to:

1. Continue to elevate the cast on pillows to prevent swelling.
2. Finish the roughened edges of the cast with adhesive tape or by pulling the stockinette over the edge and taping it to the cast.
3. Give spica casts special attention to protect the area cut out for the buttocks from becoming wet or soiled with urine or feces. Tuck a plastic wrap or bag under and over the cast edge. Change plastic wrap or bag frequently.
4. Keep the patient in proper body alignment. Change position frequently. An overhead trapeze suspended from a Balkan frame may be added to the bed to allow the patient to help himself change position.
5. Observe if any blood or drainage seeps through the cast, circle the spot with a pencil, mark the time and the date, and notify the nurse in charge.
6. Clean the cast with a damp sponge daily.
7. Use cotton tip applicators to clean areas that are hard to reach as the toes and clean up as far under the cast as possible.
8. Massage elbows, heels, back, and other bony prominences. Observe carefully for skin breakdown.
9. Continue to check frequently for symptoms of impaired circulation and for lesions that may develop under the cast.

Exercise.

Directions: View the Trainex, Care of the Patient in a Cast. After watching the Trainex, answer the questions below and on the following page. Check your answers with those on page 13 of this module.

1. List two types of casts:

   a. ______________________________

   b. ______________________________

2. Another name for a body cast is a/an ________________ cast.

3. When fractured, three bones that may require an extremity cast are:

   a. ______________________________

   b. ______________________________

   c. ______________________________

LEARNING ACTIVITIES - continued

4. If your patient is cold, cover the patient and the wet cast with blankets.
   TRUE FALSE (Circle your answer.)

5. Give two reasons why a wet cast should be supported on pillows:

   a. ____________________

   b. ____________________

6. Never turn the patient in a body cast until the cast is completely dry.
   TRUE FALSE (Circle your answer.)

7. List six symptoms of impaired circulation.

   a. ____________________

   b. ____________________

   c. ____________________

   d. ____________________

   e. ____________________

   f. ____________________

8. The Balkan frame with a ______________ may be added to the bed to assist the patient to move.

9. If any blood or drainage seeps through the cast, you must:

   a. ____________________

   b. ____________________

   c. ____________________

10. Your patient has developed a lesion under his cast. What three observations did you make that helped the doctor decide this?

    a. ____________________

    b. ____________________

    c. ____________________

11. Removing one small area of the cast to relieve pressure from swelling is called ______________.

LEARNING ACTIVITIES - continued

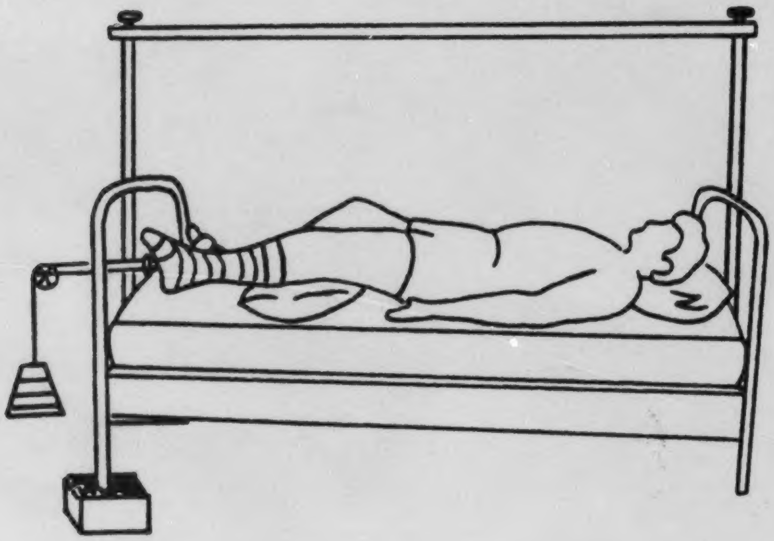
ACTIVITY #3. Care of the Patient in Traction

Directions: Read this material.

Traction is a pulling force in opposing directions. It is used to prevent muscle contraction in the treatment of some muscular deformities and in the treatment of fractures where muscular contraction pulls the broken bone out of alignment. Traction may be applied with the pull on the skin (skin or surface traction) or with the pull on the bone (skeletal traction).

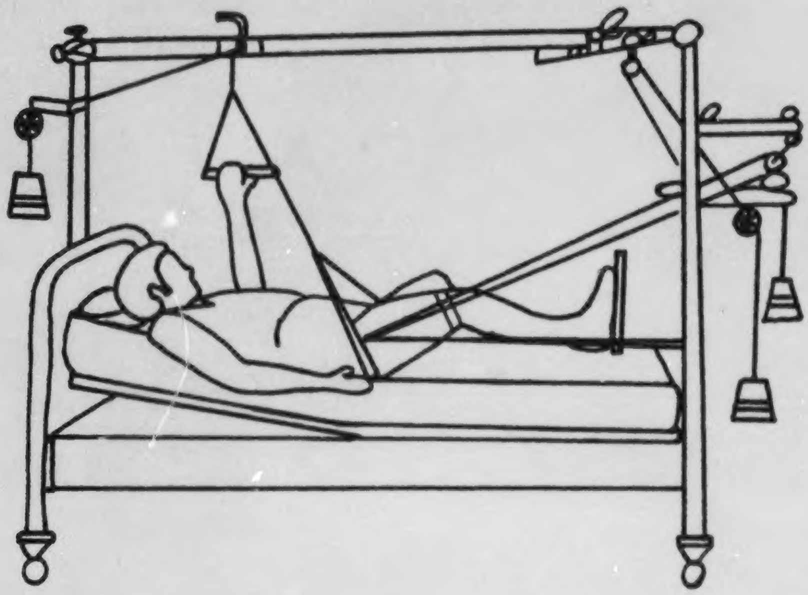
Four types of skin traction include:

(1) BUCK'S TRACTION: Buck's traction is applied to the leg for a fracture of the femur or for a dislocated hip. It may be applied to both legs in the treatment of low-back pain. To insure that the pull of traction is straight in line with the femur or hip, a pillow should support the affected leg, knee, and ankle, or, the foot of the bed may be elevated and leveled off.

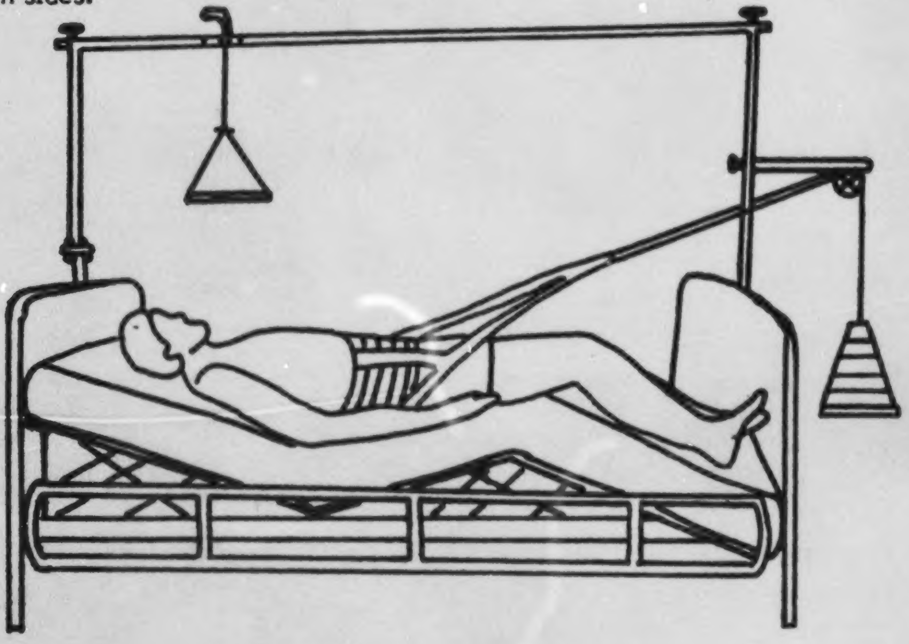


LEARNING ACTIVITIES - continued

(2) RUSSELL'S TRACTION: Russell's traction is Buck's extension with either a sling under the knee or an added pull to the knee. It is used to treat fractures of the femur.

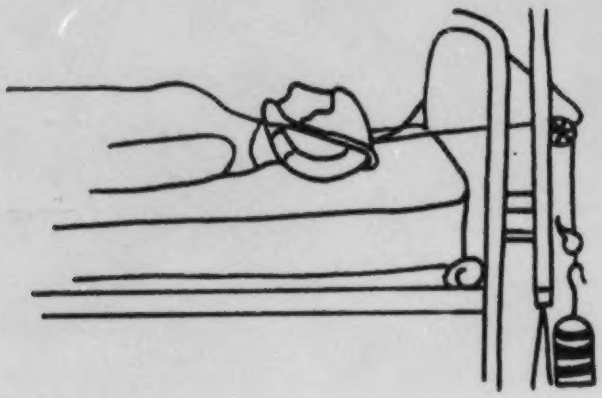


(3) PELVIC TRACTION: Pelvic traction may be prescribed to relieve pain or muscle spasm from injury to the lower back. The pelvic belt is fitted according to the patient's hip size. You may need to measure her hips by measuring around the iliac bones. The belt must be positioned so that the pull of the traction is even on both sides.



LEARNING ACTIVITIES - continued

(4) CERVICAL TRACTION: Cervical traction is applied so that the pull of the traction is in line with the patient's cervical spine or the neck portion of the spine. Traction is accomplished using a "head halter". The cervical traction is used to relieve cervical strain or whiplash.



When caring for a patient in skin traction, remember to:

1. Keep the traction constant unless otherwise ordered by the doctor.
2. Keep the patient in a proper body alignment on his back unless otherwise approved by the physician. Provide frequent back care.
3. Keep the patient from touching the head or the food of the bed. Patient's in Buck's, Russell's or pelvic traction have a tendency to slide towards the foot of the bed. To prevent this, the foot of the bed may be elevated.
4. Add a Balkan frame with overbed trapeze to the bed to allow the patient to help move in bed.
5. Check that all weights must hang free and not touch the floor. There should be no knots in the traction rope.
6. Keep the direction of the pull in a straight line with the part affected.
7. Check frequently for symptoms of impaired circulation or skin breakdown. Give skin care every four hours.
8. Never drop the weights; lower them gently. When adding weights, add them one at a time.

LEARNING ACTIVITIES - continued

Two types of skeletal traction include:

1. Steinman Pin: The Steinman Pin is surgically positioned in the bone and is used for fractures of the femur, humerus, or dislocated hip.
2. Crutchfield Tongs: Crutchfield Tongs are positioned into the cranium and are used to treat fractures of the cervical vertebrae.

The nursing care of patients in skeletal traction is the same as that of patients in skin traction. Some additional care includes:

1. Check the area around the pin or tong frequently for possible infection. Look for inflammation, drainage, swelling, pain, and/or odors. Report any symptoms immediately. Osteomyelitis or infection of the bone is a possible complication of skeletal traction.
2. Apply sterile dressings around the insertion of the pin or tong. These should be changed frequently.

Exercise.

Directions: Watch the Trainex, Introduction to Traction. After watching the Trainex, answer these questions. Answers can be found on pages 13 and 14 of this module.

1. There are two basic types of traction. Name them.

   a. ______________________________

   b. ______________________________

2. Pelvic traction is accomplished by using a pelvic belt. Where do you measure the patient to determine the size of the belt?
3. A patient with a fracture of the cervical vertebrae is in traction using Crutchfield tongs. He tells you his head aches and asks that you remove the weights for awhile. It is O.K. for you to do this, as long as the weights are not off any longer than five minutes. TRUE FALSE (Circle your answer.)
4. A patient in Russell's traction should be turned from side to side every two hours.

   TRUE FALSE (Circle your answer.)
5. The foot of the bed of a patient in traction may be elevated slightly to keep her from sliding down. TRUE FALSE (Circle your answer.)
6. When adding weights to traction, you should add them all at one time to get a sudden pulling force. TRUE FALSE (Circle your answer.)
7. When caring for a patient with a Steinman Pin, you should be very careful to check the area around the pin for signs of ________________.

LEARNING ACTIVITIES - concluded

8. ____________________ is a disease that is a possible complication of skeletal traction.

9. Name four symptoms you would look for when checking for possible infection.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

10. What is osteomyelitis? ______________________________

ANSWERS

ACTIVITY #2

1. a. extremity cast
   b. body cast or spica cast

2. spica

3. femur, knee, tibia, fibula, radius, ulna, humerus

4. FALSE

5. a. to prevent flattened areas that may press on tissue and cause damage after the cast has dried.
   b. to elevate the fractured part to help prevent edema.

6. FALSE

7. a. swelling
   b. unusual skin color
   c. toes or fingers are unusually cold
   d. inability to move fingers or toes
   e. complaints of numbness, burning, or tingling pain
   f. slow capillary refill

8. trapeze

9. a. circle the spot with a pencil
   b. mark the time and date
   c. notify the nurse in charge

10. a. drainage or stains on the cast
    b. "hot spots" felt on the cast
    c. foul odors coming from cast

11. windowing

ACTIVITY #3

1. a. skin
   b. skeletal

2. hips around the iliac bones

3. FALSE

4. FALSE

5. TRUE

6. FALSE

ANSWERS - concluded

7. infection
8. Osteomyelitis
9. inflammation, drainage, swelling, pain, odors
10. infection of the bone

NURSING ASSISTANT SKILLS

Module C1 - Back Rub

RATIONALE

In order to prevent bedsores, you must administer a back rub to your patient. A back rub stimulates the circulation which soothes and refreshes the patient.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

Demonstrate a back rub.

LEARNING ACTIVITIES

Directions: In this part of Module C, you will be asked to demonstrate a back rub. All the information you will need is included. If you have any questions, ask your instructor for help.

ACTIVITY #1. Back Rub

Directions: Read the following information.

Unless instructed otherwise, the back rub is given routinely as part of the complete bed bath or partial bath. It may also be given following the use of the bedpan or when changing the position of a helpless patient. The assistant's fingernails should be kept short to prevent any injury to the patient during the back rub. A good back rub takes from three to five minutes.

When performed properly with long, smooth strokes, the back rub stimulates the patient's circulation and aids in the prevention of bedsores. It also is soothing and refreshing.

ACTIVITY #2. Giving a Back Rub

Directions: Watch a demonstration on Giving a Back Rub by your instructor. After you have watched the demonstration, read the procedure for giving a back rub. When you demonstrate each procedure, your instructor will make comments on the steps as you accomplish them.

Procedure for Giving a Back Rub

PROCEDURE: GIVING A BACK RUB	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the necessary equipment, such as lotion or alcohol.	1. ______________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A BACK RUB — DEMONSTRATION/COMMENTS

---

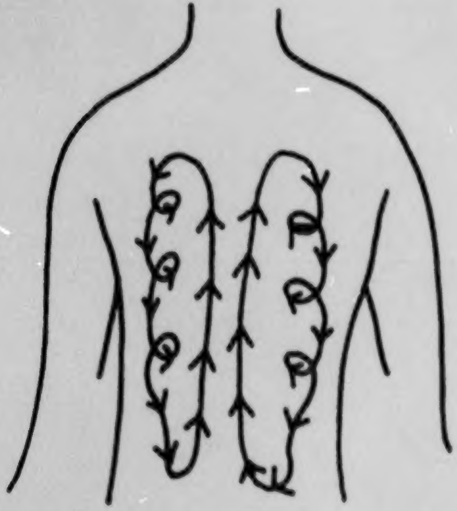
2. Tell your patient what you are going to do. — 2. ______________________

3. Screen the patient. — 3. ______________________

4. Position your patient on his side (Sim's) with his back towards you. — 4. ______________________

5. Pour a small amount of lotion into one hand. Rub your hands together to warm the lotion. — 5. ______________________

6. Apply to the patient's skin and rub with a gentle but firm motion. — 6. ______________________



7. Begin at the base of the spine, and with long, soothing strokes, rub up to the center around the shoulders, and down to the sides of the back all in a circular motion as indicated in the diagram above. — 7. ______________________

8. Repeat the procedure for 3 to 5 minutes. — 8. ______________________

9. Straighten the drawsheet and change the patient's gown. — 9. ______________________

LEARNING ACTIVITIES - concluded

PROCEDURE: GIVING A BACK RUB	DEMONSTRATION/COMMENTS
10. Replace all the equipment.	10. ____________________
11. Wash your hands.	11. ____________________

Exercise 1.

Directions: Fill in each blank with the appropriate word from the list below. Answers can be found in the previous information.

1. Rubbing the back will __________ circulation and prevent ___________.
2. In carrying out the procedure, you begin the back rub at the base of the ____________.
3. When giving a back rub, you will rub for ________ to _________ minutes.

stimulate
circulation
bedsores

neck
spine
ankle

1-2 minutes
3-5 minutes
5-10 minutes

Exercise 2.

Directions: Ask another student to act as your patient. Using the student as your patient, practice giving him a back rub. When you are ready for your instructor to observe you, take your module to him so comments may be written in the Demonstration/Comments section. Now, demonstrate to your instructor the procedure for giving a back rub.

NURSING ASSISTANT SKILLS

Module C2 - Hair Care - Shampoo, Shave, Fingernail and Toenail Care

RATIONALE

There are many things that you can do for your patients which will add to their general comfort and feeling of well being. Shaving and hair care are simple but very necessary comfort measures.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

Demonstrate:

a. Hair care

b. Giving a shampoo in bed

c. Shaving a male patient

d. Cleaning and cutting toenails and fingernails

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this part of Module C is included. Read it carefully. You will be asked to demonstrate the procedures as you care for patients in the health care facility. REMEMBER, if you have any questions, get help from your instructor.

ACTIVITY #1. Hair Care

Directions: Read the following information.

Daily care of the hair is usually performed after the patient's bed bath. Brushing the hair stimulates circulation of the scalp, refreshing the patient. It also removes dust and lint and helps to keep the hair shiny and attractive.

Procedure for Daily Care of the Hair

PROCEDURE: DAILY CARE OF THE HAIR	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the following equipment: towel, comb, brush, alcohol or petroleum jelly. (Remember, never use the same comb or brush on more than one patient.)	1. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: DAILY CARE OF THE HAIR — DEMONSTRATION/COMMENTS

2. Ask the patient to move to the side of the bed nearest to you and cover the pillow with a towel. — 2. ______

3. Brush hair carefully and thoroughly. — 3. ______

4. Ask the patient to turn her head to the side so the hair in the back of the head may be combed and brushed. — 4. ______

5. If hair is snarled, working section by section, unsnarl the hair by beginning near the ends and working towards the scalp. Applying alcohol to oily hair or petroleum jelly to dry hair also helps to unsnarl tangled hair. — 5. ______

6. Complete the brushing and arrange hair attractively. Braid long hair to prevent snarling. Clean and replace equipment. Wash your hands. — 6. ______

ACTIVITY #2. Giving a Shampoo in Bed

Directions: Read the following information.

For patients who have been confined to bed for a long time, a shampoo will not only add to their cleanliness, but will also provide comfort and a feeling of well being. The approval of the doctor must be obtained in writing on the patient's chart before the shampoo can be administered.

Procedure for Giving a Shampoo in Bed

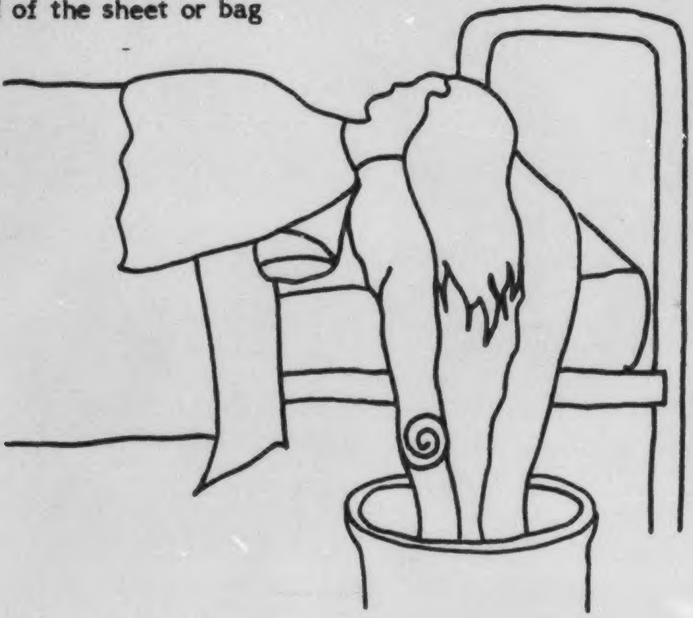
PROCEDURE: GIVING A SHAMPOO IN BED — DEMONSTRATION/COMMENTS

1. Wash hands and assemble equipment: comb and brush, shampoo, two bath blankets, two bath towels, washcloth, two large pitchers of warm water, two rubber sheets or plastic bags, large pail or basin, paper towels, and a chair. (Shampoo tray is used in some facilities.) — 1. ______

2. Roll the head of the bed flat and remove all pillows. Replace top covers with a bath blanket. — 2. ______

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A SHAMPOO IN BED	DEMONSTRATION/COMMENTS
3. Place the rubber sheet or plastic bag under the patient's head and shoulders and cover with bath towel. Remove the patient's gown to below the shoulders.	3. ________________
4. Place a chair near the head of the bed and protect it with paper towels. Place the large pail or basin on it.	4. ________________
5. Roll up the second bath blanket to form a long tube. Place this tube at the head of the bed, near the side, in a horseshoe-shaped form with the ends placed in the basin on the chair. (SEE PICTURE). Place the second rubber sheet or large plastic bag over this horseshoe drain with the bottom end of the sheet or bag placed in the basin.	5. ________________



6. Comb hair. Position the patient with head in the horeshoe drain. Give the patient the washcloth to protect her eyes.	6. ________________
7. Moisten the hair with warm water and pour a small amount of shampoo onto the hair to develop a good lather. Shampoo until hair is clean.	7. ________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A SHAMPOO IN BED	DEMONSTRATION/COMMENTS
8. Rinse the hair thoroughly. Remove the drain and the basin.	8. ____________
9. Dry hair well and arrange attractively.	9. ____________
10. Remove all the equipment and clean the unit.	10. ____________

ACTIVITY #3. Shaving the Male Patient

__Directions:__ Read the following material.

Daily shaving is part of the routine self-care of most men. This activity should not be neglected in the health care facility. When male patients are unable to shave themselves and a barber is not available, it is the nursing assistant's responsibility to shave the patient. Use the patient's own shaving equipment, if possible.

Do not shave a patient who has boils, a rash, or open cuts on his face unless instructed to do so by the nurse.

Procedure for Shaving the Male Patient

PROCEDURE: SHAVING THE MALE PATIENT	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the following equipment: shaving lather (sometimes the soap used for towel baths or soap suds enema works well for shaving), basin of warm water, towel, mirror, after-shave lotion, electric shaver or safety razor.* (__REMEMBER__, if oxygen is being used in the room, an electric shaver __CANNOT__ be used, even if it is the patient's own shaver.)	1. ____________
2. Tell the patient what you are going to do. Let him help as much as possible.	2. ____________
3. Raise the head of the bed, assemble the equipment on the overbed table, and place the towel across the patient's chest.	3. ____________
4. Moisten the face and apply the lather.	4. ____________

*Procedure above is for a safety razor.

LEARNING ACTIVITIES - continued

PROCEDURE: SHAVING THE MALE PATIENT	DEMONSTRATION/COMMENTS
5. When shaving, use firm, short strokes and shave in the direction that the hair grows. Starting under the sideburns, hold the skin taut with one hand and bring the razor down over the cheek towards the chin. Continue carefully over the chin. Repeat on the other cheek. Rinse the razor frequently.	5. ____________________
6. Lather the neck area and stroke up towards the chin in a similar manner.	6. ____________________
7. Lather the upper lip and use a downward stroke over the upper lip as the patient makes his lip taut. Be careful - this area is very sensitive.	7. ____________________
8. Wash the face and the neck and dry them thoroughly.	8. ____________________
9. Apply after-shave lotion or powder, if desired.	9. ____________________
10. If skin is nicked, apply pressure directly over the area and then an antiseptic like alcohol.	10. ____________________
11. Clean and replace the equipment. Wash hands.	11. ____________________

ACTIVITY #4. Care of Toenails and Fingernails

Directions: Read the following information.

Care of toenails and fingernails is one part of the personal care that most patients can do for themselves. However, if the patient cannot (because he is unconscious, blind, confused, in a cast or traction, or is unsteady), you may need to do it for him, but first you must check with the nurse in charge.

Usually, nail care is accomplished at the time of the regular bath. The nails should be kept clean and trimmed. In some instances, you will do the actual cleaning and cutting; in other agencies, a foot doctor (podiatrist) will be called to give this care to the patient. Do not cut toenails or fingernails of a diabetic patient or one who has circulatory disease of the lower extremities unless you have a doctor's order.

LEARNING ACTIVITIES - continued

Procedure for Cleaning and Cutting Toenails and Fingernails

PROCEDURE: CLEANING AND CUTTING TOENAILS & FINGERNAILS	DEMONSTRATION/COMMENTS
1. Wash your hands and collect the following equipment: two bath towels, basin of warm water, castile (or enema) soap, small scrub brush, nail clipper, fingernail file, and lotion.	1. ______________________
2. Mix the castile soap in the basin of warm water. Protect the bed with the bath towel. Place the patient's hand or foot into the basin of soapy water.	2. ______________________
3. Using the scrub brush, gently clean back and forth over the nails until they are clean.	3. ______________________
4. Soak the hands or feet carefully.	4. ______________________
5. Dry hands and feet carefully. Be sure to dry between the toes.	5. ______________________
6. Using the nail clipper, cut the nails straight across. The fingernail file may be used to file the sides of the fingernails.	6. ______________________
7. Apply lotion on the hands and feet and gently push back the cuticles as you rub the lotion in.	7. ______________________
8. Clean and replace the equipment.	8. ______________________

ACTIVITY #5. Demonstrate What You Have Learned

Directions: Practice and demonstrate the procedures you have learned in the lab or clinical area.

NURSING ASSISTANT SKILLS

Module C3 - Prevention and Care of Decubitus Ulcers

RATIONALE

Decubitus ulcers, also known as pressure sores or bedsores, may occur in patients of any age. To be effective as a nursing assistant, you must learn how to prevent and how to care for decubiti.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify signs, symptoms, and treatment of decubitus ulcers (bedsores).
2. Identify common sites for decubiti in the body.
3. Demonstrate care given for:
    a. prevention of decubiti
    b. caring for decubiti

LEARNING ACTIVITIES

Directions: Read the information provided and answer the questions following each section. You will be asked to demonstrate your ability to prevent and to care for decubiti as you care for patients. If you need any help, please ask your instructor. View the Trainex on "Decubiti Care".

ACTIVITY #1. Decubitus Ulcers

Directions: Read the following information.

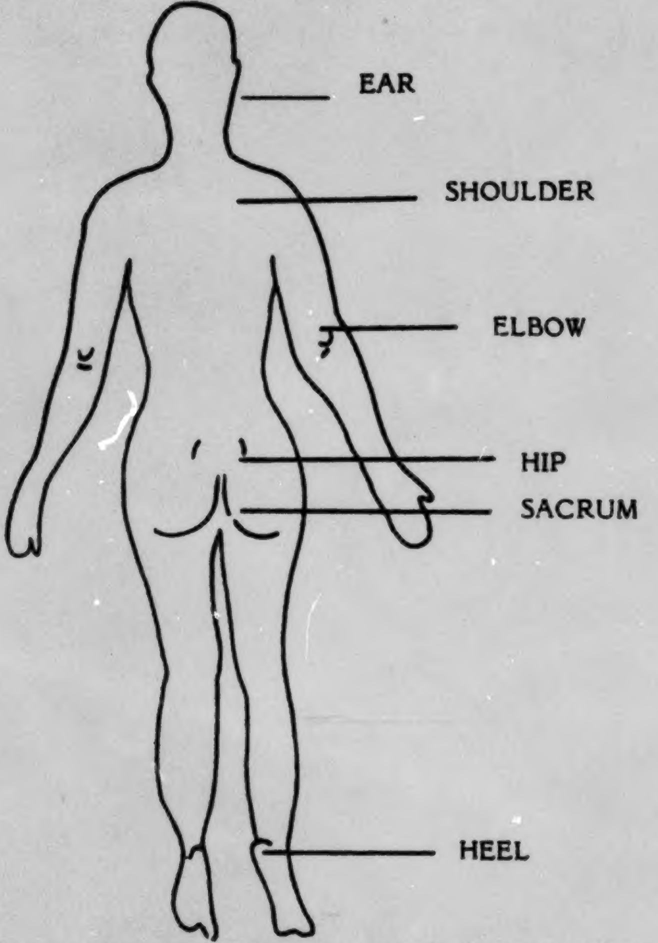
Decubitus ulcers, pressure sores or bedsores, may occur in patients of any age; but, they are particularly common in the elderly, the very thin, the overweight (obese), patients unable to move without assistance, and patients who are incontinent (lack self-control).

Decubiti result from extended pressure on one area of the body so that there is an interference with circulation. This pressure is usually from the weight of splints or casts. In some patients, only a few hours of pressure may cause the beginning of a decubitus. The skin tissue first becomes reddened and warm to the touch. The patient may complain of tenderness or a burning sensation. As the cells die from lack of nourishment, the skin may blister and then break open and an ulcer will form. Bedsores may become very large and deep, exposing the muscle and bone under the skin.

LEARNING ACTIVITIES - continued

COMMON SITES FOR DECUBITI

Decubiti occur frequently over areas where bones come close to the surface. The elbows, heels, shoulders, hips, and sacrum are the most common sites.



Obese patients tend to develop decubiti where their body parts rub together causing friction. Common sites for pressure sores or bedsores are between the folds of the buttocks, legs, and under the breasts.

Exercise

Directions: Answer these questions by filling in the blanks or by circling true or false. Answers can be found in the preceding information.

1. Pressure sores or bedsores are also known as ________________ ulcers.

2. Bedsores are more common in obese patients than in patients who are very thin.
TRUE FALSE

3. Patients paralyzed on one side of the body seldom develop pressure sores because they are constantly moving in bed. TRUE FALSE

LEARNING ACTIVITIES - continued

4. Bedsores may occur in patients of any age. TRUE FALSE

5. Decubiti result from extended pressure on one area of the body. This extended pressure causes an ulcer because it interferes with __________________.

6. List four symptoms of a decubitus that you will see before an ulcer forms.

   a. ____

   b. ____

   c. ____

   d. ____

7. Decubiti frequently occur where bones come close to the skin surface. Choose five common sites by circling the correct letters below.

   a. sacrum
   b. femur
   c. calf
   d. hip
   e. heel
   f. humerus
   g. shoulder
   h. sternum
   i. elbow

8. Pressure sores may also develop between the folds of the _____________, _____________, and under the _______________.

ACTIVITY #2. Prevention and Care of Decubiti

Directions: Read the following procedures. You will be asked to demonstrate your ability to prevent decubiti and to care for decubiti that have already developed as you care for patients in the clinical area.

Pressure sores are far more easily prevented than cured. There are many ways you can prevent decubiti. Some procedures for the prevention of decubiti are listed below.

Procedure for the Prevention of Decubiti

PROCEDURE: PREVENTION OF DECUBITI	DEMONSTRATION/COMMENTS
1. Change the patient's position every two hours. Even the patient who is sitting up may develop decubiti.	1. ____________________
2. Keep the patient's linen dry, free of wrinkles, and any hard objects such as crumbs or hairpins.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: PREVENTION OF DECUBITI	DEMONSTRATION/COMMENTS
3. Massage the reddened areas frequently with lotion. Do not use lotion on broken-skin areas.	3. ________________
4. Keep friction areas lightly dusted with corn starch. Do not allow corn starch to accumulate.	4. ________________
5. If the patient is incontinent, you may use special absorbent pads to protect his skin and the linens. Change these pads EVERY TIME he is incontinent.	5. ________________
6. Keep the patient's body clean and dry. Change the gown or linens if they are damp. Everytime the patient is incontinent of urine or feces, give careful perineal care (See Module A2 for Perineal Care).	6. ________________

ACTIVITY #3. Caring for Decubiti

Directions: Read the following material.

Once decubiti have occurred, methods to treat them will include the same methods used to prevent them. Listed below are some additional methods used to treat decubiti.

Procedure for Caring for Decubiti

PROCEDURE: CARING FOR DECUBITI	DEMONSTRATION/COMMENTS
1. Encourage the patient to exercise as much as possible to help increase circulation. If he is unable to exercise alone, you must perform ROM exercises during his bathing and turning time. (See Module B4 for Range of Motion Exercises.)	1. ________________
2. Protect the patient's skin from touching or rubbing by the use of pillows, foam pads, or sheepskins.	2. ________________
3. Expose the decubiti to air.	3. ________________

LEARNING ACTIVITIES - concluded

PROCEDURE: CARING FOR DECUBITI	DEMONSTRATION/COMMENTS
*4. Expose the decubiti to heat lamp, if ordered. (See Module C4 for Application of Heat and Cold.) Apply betadine if ordered.	4. ____________________
5. Encourage the patient to eat. Protein helps to rebuild tissues.	5. ____________________
6. Special equipment may be used to provide a continuous change of pressure caused by body weight, such as water beds, flotation mattresses, and alternating pressure mattresses. To use these, you may need a doctor's order.	6. ____________________

*Health Care Facilities use different treatments. Check with the nurse in charge.

Exercise

Directions: Answer the following questions by filling in the blanks or by circling true or false. Answers can be found on page 6 of this Module.

1. A patient should have his position changed at least every ________ even when he is sitting in a chair.

2. Friction areas include the areas between the folds of the ____________, ___________, and under the ______________. These areas should be lightly dusted with _______ ________.

3. If a patient is incontinent, you may diaper him but be sure to change him at least every two hours. TRUE FALSE

4. Exercise increases circulation. If a patient cannot exercise by himself, you must perform ______ ______ _____ for him.

5. Decubiti should be kept dry; exposing the ulcer to air or a heat lamp are two methods. TRUE FALSE

6. ______________ helps to rebuild tissue so encourage your patient to eat.

7. Always position a patient so his skin does not rub using pillows, foam pads, or sheepskins. TRUE FALSE

ANSWERS

ACTIVITY #3

1. 2 hours
2. buttocks, breast, corn starch
3. FALSE
4. Range of Motion
5. TRUE
6. Protein
7. TRUE

unit 8

NURSING ASSISTANT SKILLS

Module C4 - Application of Heat and Cold

RATIONALE

The physician frequently orders the use of hot or cold applications. It is essential that you learn how to apply them correctly in order to protect the patient from burns, injury, and unnecessary discomfort.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify four effects of a hot application and four effects of a cold application.
2. Identify safety measures employed when applying heat and cold.
3. Demonstrate:
    a. Application of a warm moist compress
    b. The hot foot or hand soak
    c. Assisting with a sitz bath
    d. The application of a heat lamp
    e. The application of an aquamatic-K pad
    f. The application of an ice cap or collar
    g. The application of a cold compress

LEARNING ACTIVITIES

Directions: You have lots of information to read and to learn in this part of Module C. Be sure to view the Trainex and to answer all questions. You will be asked to demonstrate each procedure so READ CAREFULLY. Remember, your instructor is there to help you.

ACTIVITY #1. Application of Heat

Directions: Read the following information.

Heat may be applied to an area of the body to help speed the healing process. The application of heat makes the blood vessels dilate or get wider (called vasodilation) which increases the blood supply to the injured area. This increased blood supply helps the injured tissue in four ways.

LEARNING ACTIVITIES - continued

1. By bringing in more food and oxygen so that the cells will have more energy for fighting the bacteria and repairing the injury. If a patient has had surgery to remove hemorrhoid tissues (called a hemorrhoidectomy), the physician may order the application of heat to help repair the healing tissue.

2. By bringing in more white blood cells to kill the bacteria. A scratch or wound that is infected may need heat to help kill the bacteria.

3. By absorbing excess fluids that may have accumulated in the injured tissues which cause inflammation and pain. When a patient is receiving an I.V., sometimes the needle may come out of the vein and the fluid may accumulate in the tissues under the skin causing swelling. Heat may help the patient's body to absorb that fluid and to relieve the pain caused by pressure.

4. By bringing a pocket of infection, like an abcess or a boil, to a "head" or to the surface of the skin where it may rupture and drain.

Heat applications may be either moist or dry. Moist heat is more penetrating than dry heat and includes warm moist compresses, hot foot or hand soak, and sitz bath. Dry heat is produced by Aquamatic-K pad and heat lamp.

SAFETY MEASURES

When you apply heat to the patient's body, remember excessive heat may cause further damage. It causes damage by making the cells in the heated area work so hard just to live, that they have no time or energy left to fight the infection or to heal the tissues. Be sure to follow these safety measures:

1. Always test the solution or device used to apply heat. Be sure it is at the exact temperature specified or as ordered by the physician.

2. Keep the application at the ordered temperature. If the solution cools, its effect will be the opposite of the effect desired; that is, the blood vessels will narrow instead of dilate or get wider.

3. Apply heat only for the specified length of time.

4. Watch the patient's skin carefully for excessive redness or for blistering which may indicate the beginning of a burn. If these signs develop, discontinue the heat treatment and report to the nurse in charge.

ACTIVITY #2. Local Application of Heat and Cold

Directions: View side #1 of the Trainex, Local Application of Heat and Cold. After you have seen side 1, answer the questions in the following exercise by filling in the blanks or circling TRUE or FALSE. Answers can be found on page 12 of this module.

1. Heat makes the blood vessels get wider. This widening of blood vessels is called ______________________________.

LEARNING ACTIVITIES - continued

2. When blood vessels are dilated, the blood supply to the tissues is (decreased) (increased).

3. One of the effects of heat is to help control bleeding. TRUE FALSE

4. Heat helps to repair tissue by bringing in more food and oxygen.
TRUE FALSE

5. (Red) (White) blood cells help kill bacteria.

6. If a patient has a boil, heat helps to bring the infection to the surface of the skin. TRUE FALSE

7. Heat prevents fluid from accumulating in injured tissues. TRUE FALSE

8. Heat helps excess fluid that has already accumulated in injured tissues to be absorbed. TRUE FALSE

9. Name three ways to apply moist heat.

a. ______________________________

b. ______________________________

c. ______________________________

10. Name two ways to apply dry heat.

a. ______________________________

b. ______________________________

11. Excessive heat may damage tissues. TRUE FALSE

12. It is not necessary to use a thermometer to test the temperature of a hot soak solution; the patient will tell you if it is too hot. TRUE FALSE

13. Heat should be applied only as long as the patient desires. TRUE FALSE

14. You should observe the patient's skin before applying heat and after to check for excessive redness. TRUE FALSE

15. If a heat application is allowed to cool, it is no longer an effective treatment.
TRUE FALSE

LEARNING ACTIVITIES - continued

ACTIVITY #3. Procedures for Heat Applications

Procedure for Application of a Warm Moist Compress

Directions: Read the following procedures. When you demonstrate each procedure, your instructor will check off each step as you accomplish them and make comments on your progresss.

PROCEDURE: APPLICATION OF A WARM MOIST COMPRESS	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the following equipment: basin, bath thermometer, tape, towel or dressing for compress, plastic bag to protect bed, bath towel, Aqua K-pad.	1. ____________
2. Identify patient and explain to him what you plan to do.	2. ____________
3. Screen the unit.	3. ____________
4. Preheat the Aqua K-pad.	4. ____________
5. Expose only the area to be treated and spread the plastic bag under the area to protect the bed.	5. ____________
6. Fill the basin with hot water and check the temperature with the bath thermometer - 110°-120° F.	6. ____________
7. Saturate towel or dressing for compress and wring out thoroughly.	7. ____________
8. Apply the compress.	8. ____________
9. Cover the compress with the Aqua K-pad.	9. ____________
10. Cover the Aqua K-pad with a towel and secure with tape.	10. ____________
11. Remove and discard the compress at the ordered time. Check the skin for swelling, inflammation, or irritation frequently.	11. ____________

LEARNING ACTIVITIES - continued

Procedure for the Hot Foot or Hand Soak

PROCEDURE: THE HOT FOOT OR HAND SOAK	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble equipment: basin, bath thermometer, one or two bath towels, plastic bag or rubber sheet.	1. ____________________
2. Identify patient and explain the procedure.	2. ____________________
3. Screen the unit.	3. ____________________
4. Spread the plastic bag or rubber sheet to protect the bed. Cover it with a towel.	4. ____________________
5. Fill the basin three-fourths full of warm water and check the temperature with the bath thermometer - 110° F or as ordered by the physician.	5. ____________________
6. Place the patient's hand or foot in the basin and let soak ten to fifteen minutes or as ordered by the physician.	6. ____________________
7. Check the temperature of the water frequently with the bath thermometer. Change the water as necessary to maintain the correct temperature. Do not add hot water to the basin, since this added water could burn your patient.	7. ____________________
8. When the soak is completed, dry the hand or the foot thoroughly.	8. ____________________

Procedure for Assisting with a Sitz Bath

PROCEDURE: ASSISTING WITH A SITZ BATH	DEMONSTRATION/COMMENTS
1. Wash your hands and take equipment to the bathroom: two bath towels, bath thermometer, clean gown.	1. ____________________
2. Identify the patient and explain what you plan to do.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: ASSISTING WITH A SITZ BATH	DEMONSTRATION/COMMENTS
3. Place a bath towel at the bottom of the tub.	3. ______________
4. Fill the tub ½ full of warm water and check the temperature with the bath thermometer - 110° F.	4. ______________
5. Assist the patient to the bathroom. Remove all clothing. Assist the patient into the tub.	5. ______________
6. Give the patient the call light. You may leave the patient but do not leave the room. Stay within "calling for HELP" distance.	6. ______________
7. After a few minutes, check the patient and the water temperature. Discontinue the treatment if the patient is fatigued or feels faint.	7. ______________
8. To maintain the correct water temperature, fill a pitcher with hot water and add to the tub. NEVER add hot water from the tap while the patient is still sitting in the tub. What is the correct water temperature? _____	8. ______________
9. If the patient can stand easily, assist him and run water from the tap while the patient is standing in the tub.	9. ______________
10. After twenty minutes, assist the patient out of the tub, help pat dry, and put on a clean gown.	10. ______________
11. Discard dirty linens. CLEAN the tub with cleanser and rinse well.	11. ______________

Procedure for Application of a Heat Lamp

PROCEDURE: APPLICATION OF A HEAT LAMP	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment: heat lamp, bath blanket, washcloth.	1. ______________

LEARNING ACTIVITIES - continued

PROCEDURE: APPLICATION OF A HEAT LAMP	DEMONSTRATION/COMMENTS
2. Identify the patient and explain the treatment.	2. ______________________
3. Screen the unit. Arrange the bath blanket so that only the area treated is exposed.	3. ______________________
4. Remove and discard any dressing applied to area. Observe the amount and color of the drainage on the dressing.	4. ______________________
5. Cleanse the affected area to remove the drainage or medication.	5. ______________________
6. Position the lamp - 18 to 22 inches from the patient's skin.	6. ______________________
7. Discontinue the treatment at the time ordered.	7. ______________________

Procedure for Application of the Aquamatic K-Pad

PROCEDURE: APPLICATION OF THE AQUAMATIC K-PAD	DEMONSTRATION/COMMENTS
1. Wash hands and collect equipment: K-pad and control unit, distilled water, pillowcase.	1. ______________________
2. Identify patient and tell what you plan to do.	2. ______________________
3. Place the control unit on the bedside stand. Remove the cover and fill the unit with distilled water to the "FULL" line. (This may already have been done by the Central Supply Staff.)	3. ______________________
4. Preheat the K-pad. The temperature, usually 95° to 100° F, is set by a key which is removed after setting.	4. ______________________
5. Cover the K-pad with a pillowcase and place it on the patinet.	5. ______________________

LEARNING ACTIVITIES - continued

PROCEDURE: APPLICATION OF THE AQUAMATIC K-PAD	DEMONSTRATION/COMMENTS
6. Be sure that the tubing is coiled on the bed to facilitate the flow of water to the pad. DO NOT allow the tubing to hang below the level of the bed.	6. ______________________

Exercise.

Directions: Now, take your module to your instructor. Ask another student to be your patient and demonstrate to your instructor the procedures for the application of heat.

ACTIVITY #4. Procedures for Application of Cold

Directions: Read the following information. Then answer the questions concerning application of cold.

The application of cold to the body causes the blood vessels to contract or become smaller (called vasoconstriction). When the blood vessels are contracted, the blood flow to that body area is slowed down. The affects of this decreased blood supply are to:

1. Prevent swelling. The decreased flow of blood in the area helps reduce the amount of body fluids that are carried into the injured area. By preventing swelling, pain that is caused by the pressure of swollen tissues is also prevented.

2. Control bleeding. When blood vessels are constricted, the blood flow is slowed, and less blood is able to seep out through a cut or a wound. A patient who has had his tonsils removed may have cold applied to his neck to control the bleeding.

3. Decrease the possibility of pus forming and collecting in an organ or internal area of the body. This is done when there is danger that this collection of pus may rupture and drain. A patient with an appendicitis has an infection causing the collection of pus in the appendix. This collection of pus may cause the appendix to rupture and the infection would then spread through other parts of the abdomen. To help prevent this ruptured appendix, the doctor may order cold applications to the abdomen until the appendix can be removed by surgery.

4. Reduce body temperature when the patient has a fever. The patient, whose body is weakened by disease, may not tolerate temperature elevations for very long because the body cells are already working at capacity to support life. Such patients may include heart patients, the elderly, patients with lung disease, or patients with brain injury or after brain surgery.

Cold compresses may be either moist or dry. Moist compresses will include cold compresses and a cooling bath. Dry cold is produced by an ice cap or collar.

LEARNING ACTIVITIES - continued

SAFETY MEASURES

Because cold applications reduce the blood supply to the cells and slow down the work of the cells, excessive cold causes death of the tissues (called gangrene). When applying cold, be careful to:

1. Apply cold only for the specified length of time.
2. Check frequently for signs of paleness, grayish-white appearance, cyanosis, or blueness. If the signs develop, discontinue the cold treatment and report to the nurse in charge.

Exercise 1.

Directions: Answer the following questions by filling in the blanks or circling TRUE or FALSE. Answers can be found on page 12 of this module.

1. Cold makes blood vessels become smaller; this is called ______________.
2. When blood vessels are smaller, the blood supply to the tissue is: (decreased, increased).
3. Cold helps to repair tissue by bringing in more food and oxygen. TRUE FALSE
4. Cold applications help to control bleeding and to prevent swelling. TRUE FALSE
5. When a patient has a fever, a cooling bath may help to reduce his temperature. TRUE FALSE
6. When a patient has an appendicitis, you may apply heat to the abdomen to help the pus forming in the appendix to drain. TRUE FALSE
7. Name two ways to apply moist cold.
   a. ____
   b. ____
8. One way to apply dry cold is to apply an ______________ ________.
9. Cold compresses should be applied only as long as the patient desires. TRUE FALSE
10. If you notice that your patient's skin looks pale or bluish during the cold application, you should discontinue the treatment and report it to the nurse in charge. TRUE FALSE

LEARNING ACTIVITIES - continued

Exercise 2.

Directions: View side #2 of the Trainex, Local Application of Heat and Cold.

Procedure for Application of a Cold Compress

Directions: Read the following procedures. When you demonstrate each procedure, your instructor will check off these steps as you accomplish them.

PROCEDURE: APPLICATION OF A COLD COMPRESS	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment: washcloth or dressing for compress, plastic bag or rubber sheet, small basin, ice cubes.	1. ____________
2. Identify patient and explain procedure. Answer any questions.	2. ____________
3. Spread plastic bag or rubber sheet to protect the bed.	3. ____________
4. Fill the basin with ice cubes and cool water. Place compress in basin and wring it out.	4. ____________
5. Apply compress to patient and place a second compress in water at bedside to soak.	5. ____________
6. Change as necessary to keep the compress cold. Treatment should be discontinued in 15 to 20 minutes or as ordered by the physician.	6. ____________

Procedure for Application of an Ice Bag

PROCEDURE: APPLICATION OF AN ICE BAG	DEMONSTRATION/COMMENTS
1. Wash hands and collect equipment: ice bag (plastic bag or glove), towel or ice bag cover, crushed ice.	1. ____________

LEARNING ACTIVITIES - concluded

PROCEDURE: APPLICATION OF AN ICE BAG	DEMONSTRATION/COMMENTS
2. Fill the bag one-half to two-thirds full with ice and expel air. Fasten the top securely.	2. ____________________
3. Place the ice bag in the ice bag cover or wrap with the towel.	3. ____________________
4. Identify the patient and apply the ice bag to the affected area.	4. ____________________
5. Refill the ice bag before all the ice is melted.	5. ____________________

Exercise 3.

Directions: Practice the application of cold, then demonstrate these procedures in the lab or clinical area.

ANSWERS

ACTIVITY #2

1. vasodilation
2. increased
3. FALSE
4. TRUE
5. White
6. TRUE
7. FALSE
8. TRUE
9. a. warm-moist compresses
   b. hot foot or hand soak
   c. sitz bath
10. a. aquamatic K-pad
    b. heat lamp
11. TRUE
12. FALSE
13. FALSE
14. TRUE
15. TRUE

ACTIVITY #4

Exercise 1

1. vasoconstriction
2. decreased
3. FALSE
4. TRUE
5. TRUE
6. FALSE
7. a. cold compress
   b. cooling bath
8. ice collar or ice cap
9. FALSE
10. TRUE

NURSING ASSISTANT SKILLS

Module C5 - Preparation for Sleep and Rest

RATIONALE

Everybody needs sleep. A patient is especially in need of rest to help him recover faster. As a nursing assistant, you will need to prepare the patients for sleep.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify causes and effect of interrupted sleep.
2. Identify ways to prepare a patient for sleep.

LEARNING ACTIVITIES

Directions: This is the last part of Module C. All of the information you need is included. Read carefully and answer all the questions. Remember, your instructor is there to help you.

ACTIVITY #1. Interrupted Sleep

Directions: Read the following information.

Sleep will be interrupted and wakefulness will occur as soon as the midbrain receives a message of the body need, such as the:

1. Need to be relieved of pain
2. Need to breathe more effectively
3. Need to void
4. Need to defecate
5. Need to be relieved of fear
6. Need to be turned positionwise in order to relieve a tired back

When wakefulness occurs, it is maintained for a period of time, perhaps fifteen minutes to a half hour, even after the need is met. It takes this much time for the brain activity to decrease so that sleep can occur. Each person is different and has different needs. This fact is frequently forgotten when we are caring for patients. The patient usually has difficulty adjusting to the illness, to the strange environment of the hospital, and to the enforced inactivity of lying in bed all day. Because of this, the patient may have difficulty going to sleep for the first night or two in the hospital. Prolonged periods of wakefulness disturb the functioning of the nervous

LEARNING ACTIVITIES - continued

system and may result in symptoms such as sluggishness of thought, irritability, confusion, and slow and exaggerated reaction.

Exercise

Directions: Circle the correct responses or fill in the blanks related to interrupted sleep. Answers can be found in the preceding information.

1. There are many reasons sleep is disturbed or interrupted. Some are:

    A. Need to apply makeup
    B. Need to void
    C. Need to defecate
    D. Need to be relieved of pain
    E. Need to watch T.V.
    F. Need to be relieved of fear
    G. Need to breathe more effectively
    H. Need to read

2. Prolonged periods of wakefulness may result in ____________ and ____________.

ACTIVITY #2. P.M. Care

Directions: Read the following information.

Preparing the patient for sleep consists of taking care of all the needs so that the body will not keep the brain awake with messages about its problems. All patients need your help to meet some of these needs in the preparation for sleep. Preparing the patient for bed is done in exactly the same way we prepare ourselves for bed and would include the following actions.

1. Make the patient's body comfortable:

    a. Offer bedpan or urinal.

    b. Wash hands and face. Brush the teeth. Brush the hair.

    c. Give backrub.

    d. Offer fresh water.

    e. Tighten the lower sheet and drawsheet. Straighten top linen.

2. Make the patient's mind comfortable:

    a. Make sure the call light is within reach in case she needs something.

    b. Tell the patient she will be checked on frequently during the night.

    c. Instruct her not to smoke in bed.

    d. Put the side rails up.

LEARNING ACTIVITIES - concluded

3. Make the patient's unit comfortable:

    a. Provide extra blankets.

    b. Turn out overhead lights and turn night-light on.

4. Be sure the nurse knows all about the patient's condition:

    a. Report any important observations you made about the patient while you were preparing her for sleep. These might include complaints of pain, any trouble with breathing, or restlessness.

    b. Make rounds every half hour and check the patient carefully.

Sometimes the nurse in charge may find it necessary to give the patient a sleeping pill. A sleeping pill helps the patient to go to sleep because it decreases or lessens the ability of the midbrain to receive messages from the body. Your preparation of the patient should be complete before the medication for sleep is given by the nurse.

Exercise

Directions: Answer the following questions by circling "TRUE" or "FALSE". Answers to this exercise can be found in the preceding information.

1. Hair and mouth care are done as part of P.M. care only if not done in the morning. TRUE FALSE

2. In giving P.M. care, you will change the pillowcase and bottom sheet. TRUE FALSE

3. A back rub helps to prepare the patient for sleep. TRUE FALSE

4. Ambulatory patients do not require P.M. care. TRUE FALSE

5. Only confused patients need their side rails up at bedtime. TRUE FALSE

NURSING ASSISTANT SKILLS

Module D1 - Meal Preparation and Serving

RATIONALE

Patients sometimes find it difficult to eat. You will be the person who will serve meal trays and feed the patients. Your ability to do these tasks well may determine whether the patient eats. This module will help you to assist patients at mealtime.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

Demonstrate the procedures for:

a. Preparing the patient for meals

b. Serving food trays

c. Feeding the patient

d. Removing food trays

LEARNING ACTIVITIES

Directions: In Module D you have a section of information to read, questions to answer, and a film to watch. You will be asked to demonstrate the procedures as you care for patients in the health care facility. If you have any questions, get help from your instructor.

ACTIVITY #1. Preparing the Patient for Meals

Directions: Read this information.

The body is a complex machine that keeps its organs working day and night, week in and week out, with no holidays, in order to carry on the process of living. Like every machine the body needs fuel, waste removal, and preventive maintenance in order to do this. It is very important to eat properly when you are healthy and feeling well, but it is even more important that the body be given good nourishment when a person is ill.

Most diseases affect the patient's appetite and digestion but a poor appetite does not mean you can ignore that patient's need for food. In caring for patients, part of your job is to encourage them to eat everything they are served. Be sure the room is clean, quiet, and free of any unpleasant odors. Remove things which might spoil the patient's appetite such as a dirty dressing, an emesis basin, urinal, or bedpan. The sight and smell of food often makes a patient hungry. So, you may stimulate a patient's appetite by showing or telling him what has been served. However, if a patient already has a poor appetite and feels a little nauseated, the sight of a tray

LEARNING ACTIVITIES - continued

full of food may be overwhelming. This patient may benefit from servings of one or two foods at a time in small portions. Patients also eat better if they are served foods they like. Find out from your patient or the family what foods are liked and disliked. Report the patient's requests to the nurse in charge to arrange for some of the food preferences to be served. Also, remember that foods that are hot should be served hot and foods that are cold should be served cold. Offer to heat up food that is cold by the time the patient is served.

It is difficult to eat with a dry, dirty mouth, unclean dentures, or with hands that have just assisted with toileting. Provide the patient with equipment for cleaning the mouth and brushing the teeth, especially before breakfast. Offer to clean the dentures and make sure they are replaced in the mouth when the patient is ready to eat. Always, before every meal, offer a washcloth so the patient's hands and face may be washed.

If your patient has an arm that is paralyzed, in a cast or traction, or immobilized for an intravenous injection, you will need to give extra assistance. Pour and fix the fluids, cut the meat, butter the bread, and set up the tray so that the patient can manage to eat with one arm. If your patient is totally helpless, serve the tray last so you can feed the patient. Do not increase the feelings of helplessness by serving a tray and leaving the patient alone to wonder if and when someone will come to help.

Allow the patient time to eat and enjoy the meal. Hurrying and rushing to pass out meals and collect trays must be avoided. When feeding a patient, sit at his side. Allow time for chewing and swallowing the food. The patient may seem to take a long time, but remember, he is probably very weak.

The patient's diet is a very special part of the treatment and is specifically prescribed by the doctor. The physician may order a special diet that is used to treat a particular condition. These special diets are known as therapeutic, restricted, or modified diets and require preparation that differs from those regularly prepared for other patients in the health care facility. A list of special diets is provided on the next page. You will learn more about special diets in Unit 5 covering Nutrition. Because many patients have special diets ordered, you must be alert for visitors who might want to give a patient certain foods that are not allowed. When a patient asks you for something that is not on the tray, check the diet slip or check the diet ordered on the Kardex before bringing it to him. If the patient is on a special diet, ask the nurse in charge if it is alright for the patient to have the food. You must be very careful to observe your patient as he eats. Report to the nurse in charge the following: the patient's appetite, the intake, his refusal to eat certain foods, and any difficulties he may have had in eating.

LEARNING ACTIVITIES - continued

DIETS

DIET	DESCRIPTION	PURPOSE
Normal or Regular	Balanced in carbohydrates, protein, fats. Cooked and seasoned as desired.	For patients with no special diet needs.
Liquid	CLEAR: Liquids you can see through like broth, tea, 7-Up, Jello.	For patients with nausea, vomiting, diarrhea.
	FULL: All liquids and foods that become liquid on eating like custards, ice cream, creamed soup.	First stage diet for patients who have had surgical operations.
Soft	Foods soft in consistency, no rich or highly seasoned foods.	For patients with G-I disorders. Final-stage diet for surgical patient before resuming a regular diet.
Mechanical Soft	Foods of a regular diet that are chopped or are strained.	For patients who have some difficulty chewing or swallowing.
Bland	Foods easy to digest and mild in flavor; no spicy seasonings.	For patients with G-I disorders such as ulcer or colitis; avoid any irritation to the digestive tract.
Low Residue	Foods easy to digest and low in fiber or bulk; no skins or seeds.	For patients with lower colon or rectal diseases.
Diabetic	Diet individualized according to patient's insulin and nutritional requirements. Exact balance of carbohydrate, fat, and protein using food exchange system.	For diabetic patients.
High Protein	Foods high in protein such as milk, meat, fish, cheese, eggs, added to supplement the diet.	For growth and repair of tissue as for patients with muscular-skeletal disease, cirrhosis of the liver, hepatitis.

LEARNING ACTIVITIES - continued

DIETS

DIET	DESCRIPTION	PURPOSE
Low Fat	Controlled amounts of foods high in fat such as butter, cream, cheese, pastry.	For patients who have difficulty digesting fats as in gallbladder or liver diseases.
Low Cholesterol	Controlled amounts of foods high in cholesterol such as butter, eggs, whole milk, meats.	For patients with high levels of cholesterol in their blood as in atherosclerosis.
Low Sodium	May use some salt in cooking; no extra salt for seasoning; controlled amounts of foods high in sodium such as bacon, ham.	For patients with fluid retention problems as in kidney and cardiac conditions.
Tube Feeding	Liquid formula of milk-base and blenderized meat and vegetable. Commercial formula preparations available. Given to patients through a tube going from the nose to the stomach or a tube directly into the stomach or intestines.	For patients unable to swallow as in surgery involving the mouth or esophagus, or in the patients with neurological damage.

ACTIVITY #2. Serving Food Trays

Directions: In the section below marked ACTIONS you will find six possible nursing actions you will take in certain situations. In the section on the following page marked WHAT WOULD YOU DO you will find 15 situations which require nursing care. Place the letter for the correct action in the space provided after each situation. Answers can be found on page 10 of this module.

ACTIONS

A. Get the item for the patient

B. Feed the patient

C. Prepare the patient for eating his/her meal

D. Check the diet slip for the patient's name

LEARNING ACTIVITIES - continued

E. Look at the tray yourself

F. Check the diet slip or the Kardex to see if the patient may have the item.

WHAT WOULD YOU DO

1. When you take a meal tray to a patient? ____________________
2. If your patient tells you he did not get a spoon? ____________________
3. If there is no spoon on the tray? ____________________
4. When your patient tells you his mouth tastes too awful to eat? ________________ (By doing what? ____________________________________)
5. If your patient has both arms in a cast? ____________________
6. If your patient tells you he did not get any salt on the tray? ________________ and ____________________
7. If you see a milk carton on the tray, but not a cup? ________________
8. To find out if your patient received the right tray? ________________
9. If your patient has both eyes covered with a dressing? ____________________
10. If your patient on a regular diet did not get any sugar on the tray and wants some? ____________________________________
11. If your patient tells you he did not get any coffee? ________________ and __________
12. If your patient's arm is immobilized by an I.V.? _______________ (By doing what? ____________________________________)
13. If your patient tells you he has the wrong tray? ____________________
14. When visitors bring candy to your patient? ____________________
15. When your patient asks you for some orange juice? ____________________

ACTIVITY #3. Feeding the Patient

Directions: Watch the Trainex, Feeding the Patient. As you watch the Trainex, fill in the following statements. Answers can be found on page 10 of this module.

1. The food trays usually arrive on the nursing unit in a ____________________ .
2. You will begin the meal procedure by ________________________________ .

LEARNING ACTIVITIES - continued

3. Each tray will have a slip that states what three items?

   a. ______________ b. ______________ c. ______________

4. You will fill the cups or the glasses ______________ full.

5. You will carry the trays ______________ high.

6. To be certain the patients receive the right trays, you will check ______________; the name should be the same as the name on the ______________.

7. Remove the ______________ from the food tray.

8. You will arrange the ______________ and ______________ for the patient's convenience.

9. To help the patient eat, you will:

   a. ______________ b. ______________ c. ______________

10. Always be ______________ and work ______________.

11. The patient may refuse the food if he is ______________ .

12. You and the patient may feel more relaxed if you ______________ by the bedside.

13. To feed the patient, place a ______________ across his chest.

14. Place the food where he can see it or ______________ the patient what food is on the meal tray.

15. Permit the patient to help by ______________ or ______________.

16. Allow the patient ______________ to chew the food.

17. Tell him if the food or liquid is too ______________.

18. You will ______________ with the patient during the meal.

19. If the patient is blind for a short time, you will need to ______________ and ______________.

LEARNING ACTIVITIES - continued

ACTIVITY #4. Meal Preparations and Serving

Procedure for Preparing the Patient for Meals

Directions: Read the procedures on the following pages. When you demonstrate each procedure, your instructor will check off these steps as you accomplish them and make comments on your performace.

PROCEDURE: PREPARING THE PATIENT FOR MEALS	DEMONSTRATION/COMMENTS
1. Allow the patient to clean the mouth and brush the teeth. Offer to clean the dentures. Offer the bedpan or urinal. Allow the patient to wash the hands and face.	1. ________________
2. Help the patient to a chair to eat at the overbed table. If this is not possible, help the patient to sit on the edge of the bed and dangle the feet or raise the head of the bed to a sitting position so the patient can sit in bed.	2. ________________
3. Remove unnecessary articles from the bedside table and wipe the table clean. Move the overbed table to a convenient position.	3. ________________
4. Protect the patient's gown with a napkin or small face towel, if necessary.	4. ________________
5. Place the food tray in most convenient position for the patient.	5. ________________
6. Assist the patient to set up tray as necessary: a. pour liquids b. cut the meat c. open the containers d. season the foods e. butter the bread	6. ________________

LEARNING ACTIVITIES - continued

Procedure for Serving Food Trays

PROCEDURE: SERVING FOOD TRAYS	DEMONSTRATION/COMMENTS
1. Prepare the patient to eat.	1. ____________________
2. Wash your hands.	2. ____________________
3. Find the name on the diet slip on the food tray located in the food cart.	3. ____________________
4. Identify the patient by checking the name on the diet slip with the patient's wristband.	4. ____________________
5. Place the tray on the overbed table and assist the patient as necessary.	5. ____________________
6. Return to the food cart and repeat all the steps until all trays have been served.	6. ____________________

Procedure for Feeding the Patient

PROCEDURE: FEEDING THE PATIENT	DEMONSTRATION/COMMENTS
1. Prepare the patient to eat.	1. ____________________
2. Sit down facing the patient.	2. ____________________
3. Encourage the patient to do what she can for herself. Allow her to hold the bread or the drinking straw.	3. ____________________
4. Give food from the tip of the spoon or fork. Give liquids slowly through a straw. If the patient has trouble sucking on a straw, you may need to use a spoon to feed fluids into the mouth.	4. ____________________
5. Alternate the food as the patient desires. Explain what is being offered each time you give something new.	5. ____________________
6. Allow the patient enough time to chew and swallow the food. Do not rush.	6. ____________________

LEARNING ACTIVITIES - concluded

PROCEDURE: FEEDING THE PATIENT — **DEMONSTRATION/COMMENTS**

7. Dry the patient's lips with the napkin, as necessary. 7. ______________________

8. Talk with her during the meal. 8. ______________________

Procedure for Removing the Food Trays

PROCEDURE: REMOVING THE FOOD TRAYS — **DEMONSTRATION/COMMENTS**

1. Observe how much of the food the patient has eaten. 1. ______________________

2. If the patient is on INTAKE and OUTPUT, observe and record the intake of fluids on the I & O sheet. List nine foods which are fluids: 2. ______________________

   a. ____________ f. ____________

   b. ____________ g. ____________

   c. ____________ h. ____________

   d. ____________ i. ____________

   e. ____________

3. Remove the empty food tray and take it to the food cart. 3. ______________________

4. Leave the coffee or the tea for the patient to finish. 4. ______________________

5. Assist the patient to wash the hands and brush the teeth as requested. 5. ______________________

Exercise. Demonstrations

Directions: Demonstrate each procedure, under your instructor's supervision, as you care for the patients in the health care facility. After you have performed each procedure, take the checklist in your module to your instructor and ask for comments on your performance.

ANSWERS

ACTIVITY #2

1. D
2. E
3. A
4. C - Offer the equipment for cleaning the mouth and brushing the teeth.
5. B
6. E, F
7. A
8. D
9. B
10. A
11. E, F
12. C - Pour the liquids, cut the meat, season the food, put butter on the bread, and set up tray so the patient can manage alone.
13. D
14. F
15. F

ACTIVITY #3

1. cart
2. washing your hands
3. a. patient's name
   b. type of diet
   c. room number
4. half
5. waist
6. (1) identification band
   (2) diet slip
7. covers
8. (1) utensils - knife, fork, spoon
   (2) napkin
9. a. place everything in easy reach
   b. cut the meat
   c. pour liquids
10. (1) pleasant - friendly
    (2) calmly
11. rushed
12. sit
13. napkin
14. tell
15. letting him hold the drinking straw or bread
16. time
17. hot
18. talk (converse)
19. (1) describe the food
    (2) tell the patient what he/she is eating

NURSING ASSISTANT SKILLS

Module D2 - Enema Procedure

RATIONALE

Enemas may be given to a patient to clean out the bodily waste or fecal material, to relieve flatus or gas in the intestines, or as a preparation for x-rays or diagnostic procedures. This part of Module D will discuss the different kinds of enemas, their purposes, and the procedures used for giving each one.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Write the definitions for ten vocabulary words.
2. Identify the types of enemas.
3. Identify the procedures used when giving a:
   a. Cleansing enema
   b. Fleet enema
   c. Oil retention enema
   d. Tidal wave enema
4. Demonstrate the four basic types of enemas.

LEARNING ACTIVITIES

Directions: In this part of Module D you will view a Trainex and be asked to do demonstration procedures. The section labeled DEMONSTRATION/ COMMENTS is for your instructor to use to make comments while you demonstrate the steps for each procedure. You have four different enema procedures to demonstrate, so GET BUSY!!

ACTIVITY #1. Terminology

Directions: Write the definitions to the vocabulary words listed below. You may use the terminology section at the end of the unit or your dictionary.

1. Constipation: ______________________________
2. Diarrhea: ______________________________
3. Defecation: ______________________________

LEARNING ACTIVITIES - continued

4. Dilate: ______________________________

5. Flatus or Flatulence: ______________________________

6. Hemorrhoids: ______________________________

7. Lubricate: ______________________________

8. Peristalsis: ______________________________

9. Retention: ______________________________

10. Enema: ______________________________

ACTIVITY #2. Types of Enemas

Directions: Read this information.

A doctor's order is necessary before an enema is given. The doctor will specify the kind of enema to be given. There are four basic types of enemas.

1. Cleansing Enemas which may include:
    a. Soap Suds Enema
    b. Saline Enema
    c. Tap Water Enema
2. Fleet Enema
3. Oil Retention Enema
4. Tidal Wave Enema also called the "Harris Flush"

Exercise.

Directions: Watch the Trainex, "Cleansing Enemas". Then ask your instructor to demonstrate giving a fleet enema and a tidal wave enema. If you have any questions, be sure to ask your instructor.

ACTIVITY #3. Procedures on Giving Enemas

Directions: Read the following material. Then read the procedures on the following pages. When you demonstrate each procedure, your instructor will check off these steps as you accomplish them and make comments on your performance.

The cleansing enema is ordered by the doctor to relieve constipation, flatus or flatulence, or to remove fecal material from the lower bowel. Patients will receive a cleansing enema before an x-ray such as a Barium Enema or to prepare them for a diagnostic procedure such as a proctoscopy (examination of rectum with a scope).

LEARNING ACTIVITIES - continued

*A cleansing enema may be a:

1. Soap Suds Enema (S.S.E.) - use enema soap packet to 1000 cc's of water.
2. Saline Enema - use one teaspoon salt to 500 cc's of water.
3. Tap Water Enema (T.W.E.) - use approximately 1000 cc's tap water.

*Each of these may be administered as a three position enema which is explained in the following procedure.

Procedure for Giving a Cleansing Enema

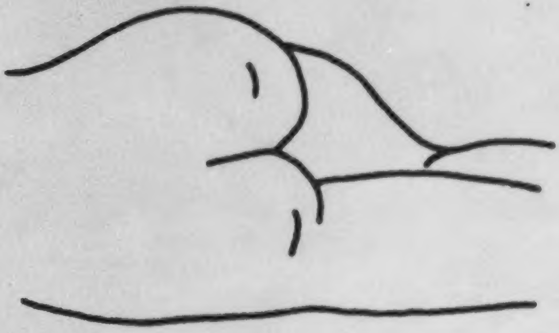
PROCEDURE: GIVING A CLEANSING ENEMA	DEMONSTRATION/COMMENTS
1. Prepare the solution ordered by the doctor in the utility room. How would you prepare the solution for each of these enemas? Prepare enema at temperature of 105° - 110° F AS ORDERED. a. S.S.E. b. Saline c. T.W.E. EQUIPMENT: Disposable enema set-up plastic square or chux towels lubricant disposable nonsterile gloves	1. ____________________
2. Explain procedure to the patient. Clear the bedside table where you will place the equipment.	2. ____________________
3. Allow some of the solution to flow out of the tubing to expel air and clamp the tubing. Air introduced into the bowel will cause distention and discomfort.	3. ____________________
4. Place the solution container at the proper height. The base of the solution container should be no higher than 12 inches above level where tube enters the anus. If you are measuring from the level of the bed, hold the enema container about 18 inches above the bed level.	4. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A CLEANSING ENEMA

DEMONSTRATION/COMMENTS

5. Screen the patient and replace top covers with bath blanket by fan folding covers to bottom of bed. Position patient in Sim's Position on the left side with a plastic protector or chux under the buttocks.



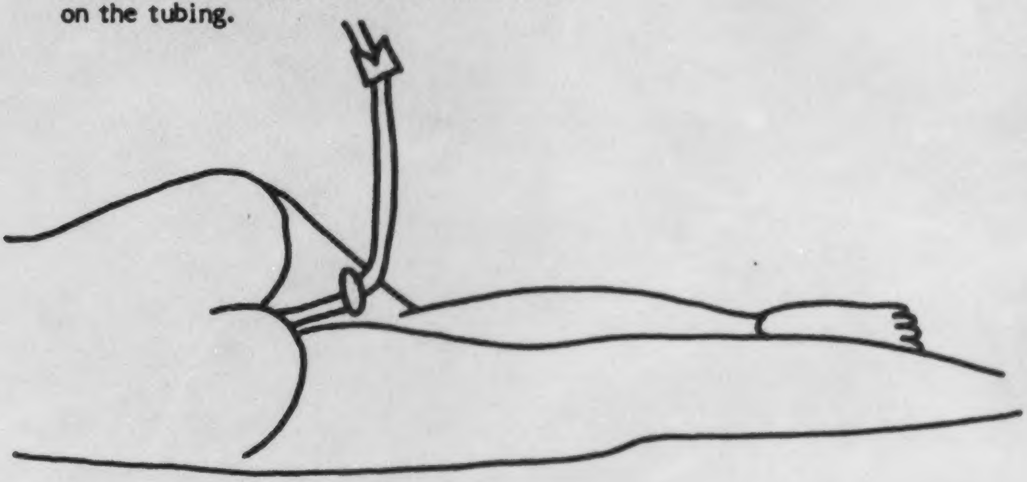
5. ____________________

6. Lubricate the end of the tube.

6. ____________________

7. Raise the upper buttocks so that you can expose the anus and insert the tube slowly and gently into the anus about three - four inches or to the first mark on the tubing.

7. ____________________



LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A CLEANSING ENEMA	DEMONSTRATION/COMMENTS
8. Instruct the patient to breathe deeply. Open the clamp and allow approximately 1/3 of solution to run into the rectum slowly. If the patient complains of cramping or discomfort, clamp the tube and instruct patient to breathe deeply, then reopen clamp and allow remaining solution to run in slowly.	8. ____________________
9. Close the clamp while there is still some solution left in the container to prevent air from entering the bowel. Remove the tube - slowly and gently. Cover the end of the tube with tissue and place it on the tray.	9. ____________________
10. Encourage the patient to retain the solution as long as possible.	10. ____________________
*11. If administering the three position enema, clamp tubing when the first 1/3 of solution is gone. Place patient on back and allow another 1/3 of remaining solution to run into the rectum.	11. ____________________
*12. Clamp tubing once more and instruct the patient to turn to the Sim's Position on the right side. Open the clamp and give the remaining 1/3 solution. Encourage the patient to retain the solution as long as possible.	12. ____________________
13. Turn patient on back and assist patient onto the bedpan, to the bedside commode, or to the bathroom. Place toilet tissue and the call light within easy reach of patient.	13. ____________________

*Numbers 11 and 12 refer to the three position enema.

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A CLEANSING ENEMA — DEMONSTRATION/COMMENTS

14. Check the bedpan or commode for results, observe for the amount, the color, the consistency of the stool and for unusual discharges such as blood or pus. Report the enema results and the patient's tolerance to the procedure to the nurse in charge and instructor.

14. ____________________

15. Return enema container to the patient's bedside stand after cleaning all equipment well.

15. ____________________

Procedure for Giving the Fleet Enema

Directions: Read the following.

The fleet enema is a treatment used to flush the bowel to relieve constipation or flatulence, or to remove feces from the lower bowel. Fleet enemas are sent to the unit from the pharmacy.

PROCEDURE: GIVING THE FLEET ENEMA — DEMONSTRATION/COMMENTS

1. Explain the procedure to the patient.

1. ____________________

2. Screen the patient and position her in the Sim's Position on the left side with a protective pad under the buttocks. Remember, the large colon descends on the left side.

2. ____________________

3. Remove the cover of the enema tip and insert the pre-lubricated tube into the anus - the full length of the tube.

3. ____________________

4. Squeeze the bottle gently until the desired amount of the solution has been administered and remove the tube.

4. ____________________

5. Instruct the patient to hold or retain the solution until the urge to defecate becomes strong - at least 2 to 5 minutes. If the patient expels the solution immediately, the colon will not be cleaned out.

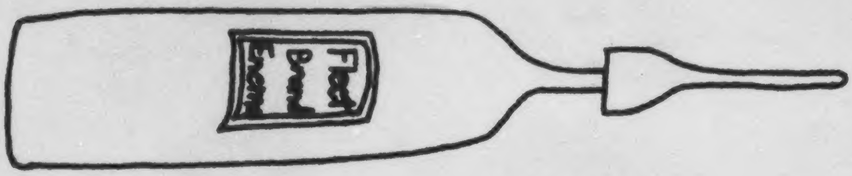
5. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING THE FLEET ENEMA	DEMONSTRATION/COMMENTS
6. Assist the patient onto the bedpan, to the bedside commode, or to the bathroom. Be sure to instruct the patient not to flush the toilet.	6. ______________
7. Observe and report the results to the nurse in charge.	7. ______________

List four things you would observe:

a. __________ b. __________ c. __________ d. __________



Procedure for Giving an Oil Retention Enema

Directions: Read the following.

The doctor will order an oil retention enema to aid in softening hard stool and to lubricate the lower colon making defecation easier. This enema is sent to the unit from the pharmacy. A cleansing enema may be ordered after the oil retention enema has been given.

PROCEDURE: GIVING AN OIL RETENTION ENEMA	DEMONSTRATION/COMMENTS
1. Warm the enema container in a graduate pitcher filled with water - 110° F for ten minutes. You want the oil warm to help soften the stool.	1. ______________
2. Explain the treatment to the patient.	2. ______________
3. Screen the patient and position her in Sim's Position on the left side with a protective pad under the buttocks.	3. ______________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING AN OIL RETENTION ENEMA	DEMONSTRATION/COMMENTS
4. Lubricate the tube.	4. ______________________
5. Gently insert the tube and squeeze the bottle until all the oil has been inserted. Insert the oil slowly as you want to reduce the desire to expel the oil.	5. ______________________
6. When the container is empty, remove the tube from the anus and apply pressure gently to the anus to avoid spontaneous defecation. Have the patient turn on her back.	6. ______________________
7. Instruct the patient to retain the oil as long as possible. Make her comfortable. Leave the protector on the bed because a small amount of the oil will leak from the rectum. Assist to bathroom, if necessary.	7. ______________________
8. Do not forget to report to the nurse in charge the time the enema was given, how the patient tolerated the treatment, and how long the oil was retained.	8. ______________________

Procedure for Giving a Tidal Wave Enema

Directions: Read the following.

The doctor will order a tidal wave enema to relieve flatus in the colon by allowing water to flow in and out of the rectum, bringing with it the gas it has absorbed. A tidal wave enema is also called a "Harris Flush".

PROCEDURE: GIVING A TIDAL WAVE ENEMA	DEMONSTRATION/COMMENTS
1. Prepare 500 cc's tap water to 105-110° F in a regular enema container. Be sure to do this in the utility room.	1. ______________________
2. Explain the treatment to the patient. Remember, explanations help to relieve apprehensions and fear.	2. ______________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A TIDAL WAVE ENEMA	DEMONSTRATION/COMMENTS
3. Screen the patient and position in Sim's Position on the left side with an absorbent protective pad under the buttocks.	3. ____________
4. Remove air from the tubing and lubricate the tip.	4. ____________
5. Expose the anus and insert the tube 4 - 6 inches. Never force the tubing.	5. ____________
6. Hold the enema can about 12 inches above the level of the bed. Allow approximately 100 cc's of the solution to run in.	6. ____________
7. Lower the can 12 inches below the level of the bed to allow the return flow of the solution - the gas will come out with the solution.	7. ____________
8. Repeat the process slowly. That is, allow the solution to run in and then lower the can. Do this for a ten-minute period.	8. ____________
9. Continue the procedure, if necessary, until there is no more bubbling from the solution flowing back into the can.	9. ____________
10. Procedure should be completed following the return flow of solution into the can to avoid the patient retaining it.	10. ____________
11. Do not forget to report the amount of the gas expelled, the patient's reaction to the treatment, and anything unusual, to the nurse in charge.	11. ____________
12. Have you left the patient clean and comfortable? Did you clean and put the equipment away?	12. ____________

LEARNING ACTIVITIES - concluded

Exercise.

Directions: Now, use the mannequin, "Mrs. Chase", as your patient and demonstrate to your instructor the procedure for giving each of these enemas:

1. Cleansing Enema
2. Fleet Enema
3. Oil Retention Enema
4. Tidal Wave Enema

Before giving each enema, explain the procedure to your patient in words your patient can understand.

NURSING ASSISTANT SKILLS

Module D3 - Rectal Tube Insertation

RATIONALE

If you were asked to insert a rectal tube and your patient asked you, "What is that thing for?", could you tell him? This module will help you to answer this question and it will tell you how to safely insert the tube.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

Demonstrate the procedure for inserting a rectal tube.

LEARNING ACTIVITIES

Directions: This is a short module. All of the information you need to complete this part of Module D is included. You will be asked to demonstrate the procedure as you care for patients in the health care facility.

ACTIVITY #1. Inserting A Rectal Tube

Directions: Read the following material.

A rectal tube is ordered by the physician to relieve flatus that has accumulated in the colon. It is not a treatment to cleanse the colon of stool. The equipment you will need is ordered from Central Supply. It is called a Flatus Bag Set and consists of a rectal tube with a plastic bag attached to the open end.

Procedure for Inserting a Rectal Tube

Directions: Read this procedure and answer the questions. When you demonstrate this procedure, your instructor will check off the steps as you accomplish them and make comments.

PROCEDURE: INSERTING A RECTAL TUBE	DEMONSTRATION/COMMENTS
1. Explain the procedure to the patient.	1. ______________
2. Screen the patient and position him in Sim's position on the left side. Cover the patient with a bath blanket.	2. ______________
3. Lubricate the tube.	3. ______________

LEARNING ACTIVITIES - concluded

PROCEDURE: INSERTING A RECTAL TUBE	DEMONSTRATION/COMMENTS
4. Expose the anus and insert the rectal tube into the rectum about 5 to 8 inches.	4. ____________
5. Hold the tube in place a few minutes as flatus may partially expel the tube.	5. ____________
6. Leave the tube in place twenty minutes or for the time specified by the doctor. Remove the tube and empty the bag attached to the end of the tube.	6. ____________
7. Rinse the equipment with cold water. Then wash with hot soapy water, rinse well, place the equipment in its box, and put it in the patient's bedside table to be used again.	7. ____________
8. Report the results to the nurse in charge. Be sure to include the approximate amount of flatus expelled, how the patient tolerated the procedure, and how he felt after the treatment.	8. ____________

Exercise.

Directions: Answer these questions by filling in the blanks. Answers can be found in the preceding information.

1. When you explain the procedure for inserting a rectal tube to your patient, what would you say? ____________________

   ____

   ____

2. A rectal tube is ordered by the physician to ____________________ .
3. Where do you get the Flatus Bag Set? ____________________
4. How far into the rectum would you insert the rectal tube? ____________
5. If there is no specified time, how long would you leave the rectal tube in the rectum? ____________________

NURSING ASSISTANT SKILLS

Module D4 - Fecal Impaction

RATIONALE

You may be asked to check a patient for a fecal impaction and to remove it. Do you know how? Even more important is how to prevent a fecal impaction from occuring. This module will help you learn how to prevent fecal impactions and remove, if necessary.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate the procedure for:
    a. Checking for a fecal impaction
    b. Removing a fecal impaction
2. Participate in group discussion on methods used to prevent fecal impactions.

LEARNING ACTIVITIES

Directions: Read the information and answer all questions. Everything you need is included. In most facilities, nursing assistants do not remove impactions, so check with your instructor before completing this activity. If you are a practical nursing student, you should do this.

ACTIVITY #1. Removing A Fecal Impaction

Directions: Read the following material.

A "fecal impaction" is the term used to describe the hard stool or fecal material that blocks the colon and cannot be expelled by the patient. Some patients may seem like they have diarrhea but are actually impacted. The hard stool blocks the colon so that only watery stool can escape from around the block. Often even enemas will not help the patient expel the stool and you may need to help remove it with your fingers.

Directions: Read the procedure on the next page. When you demonstrate this procedure, your instructor will check off the steps as you accomplish them.

LEARNING ACTIVITIES - continued

Procedure for Removing a Fecal Impaction

PROCEDURE: REMOVING A FECAL IMPACTION	DEMONSTRATION/COMMENTS
1. Explain the procedure to the patient.	1. ____________
2. Screen the patient and position him in Sim's Position on the left side.	2. ____________
3. Put on a disposable glove and lubricate your finger closest to the thumb.	3. ____________
4. Insert your finger gently into the rectum. If the patient has an impaction, you will feel it on the tip of your finger.	4. ____________
5. Report this to the nurse in charge before you remove it.*	5. ____________
6. To remove the impaction, follow the above steps, but when you feel the impaction, attempt to break it up with your finger.	6. ____________
7. Dilate the rectal muscle by using a gentle rotating motion with your finger and try to pull the stool down and out of the anus. This is called "manually extracting" fecal material. Dilating the sphincter helps to stimulate peristalsis. It may also help if your patient can bear down as if trying to have a bowel movement.	7. ____________
8. If rectal bleeding occurs, STOP, and report this to your team leader. The patient may have hemorrhoids and they may bleed when the rectum is dilated.	8. ____________
9. After you have removed the stool, be sure and clean the patient's rectal area with warm soapy water and a washcloth. The warm water will soothe the rectal area. Dry the area thoroughly with a towel.	9. ____________
10. Report the results to the nurse in charge.	10. ____________

*__Remember:__ In some facilities, nursing assistants are not allowed to remove impactions.

LEARNING ACTIVITIES - concluded

Exercise.

Directions: Answer these questions by filling in the blanks or by circling TRUE or FALSE. Answers may be found in the preceding information.

1. The hard stool that blocks the colon and cannot be expelled by the patient is called a ______________ ______________.
2. Patients with impactions will always be constipated. TRUE FALSE
3. To remove an impaction, the patient is placed in ____________ position on his __________ side.
4. When you remove the fecal materials with your finger, it is called "______________ ______________" fecal material.
5. If the patient starts bleeding during the procedure, what do you do? ________ ______________________________

ACTIVITY #2. Preventing Fecal Impactions

Directions: Read the following material and then, with your instructor and other students, discuss ways of preventing fecal impactions.

Constipation which results in fecal impactions can sometimes be prevented by good nursing care. As a nursing assistant you should help the patients get up and move around as much as the doctor will allow. Lying in bed will decrease the activity (peristaltic action) of the bowel and allow the stool to harden.

Helping your patient maintain adequate dietary and fluid intake will assist with keeping the stool soft. (See Unit 5, Module D for a discussion on diets.) Many people have certain items they eat, such as prunes or apples to help keep them regular. As a nursing assistant you may be able to order these items from the diet kitchen if they are on the patient's diet prescribed by the doctor. Drinking plenty of fluids is also important in maintaining regular bowel habits.

The last important point is to keep your patient on a regular schedule so that they go to the bathroom every day at the same time. This can be very necessary for some people to avoid constipation.

Remember!

1. Moderate exercise if allowed.
2. Drink plenty of fluids.
3. Eat nutritious food.
4. Maintain a regular schedule.

LEARNING ACTIVITIES - concluded

Remember!

1. Moderate exercise if allowed.
2. Drink plenty of fluids.
3. Eat nutritious food.
4. Maintain a regular schedule.

unit 8

NURSING ASSISTANT SKILLS

Module D5 - Collection of Stool Specimens

RATIONALE

The physician may order that a stool specimen be collected for an examination to assist in making the diagnosis of a disease. To help the doctor make an accurate diagnosis, you must know the correct procedure used for stool collection.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Match vocabulary words with meanings.
2. Answer written questions relating to the procedure for collecting:
    a. Stool specimens for culture
    b. Stool specimens for ova and parasites
    c. Stool specimens for occult blood or guaiac
3. Demonstrate the procedures for:
    a. Collecting stool specimens
    b. Developing and reading hemoccult slides

LEARNING ACTIVITIES

Directions: Be sure to learn the vocabulary words before reading the rest of the material. Answer all of the questions. If you need help, your instructor is available.

ACTIVITY #1. Terminology

Directions: Learn these vocabulary words.

1. Parasite: An organism that lives and feeds off the patient.
2. Ova: Eggs.
3. Bacteria: Micro-organisms; some may cause disease and others may not.
4. Barium: A soft, metallic element used to visualize the gastrointestinal tract in x-rays. The barium may be swallowed or given as an enema.

LEARNING ACTIVITIES - continued

5. Occult blood: Blood that is concealed; blood not visible to the naked eye.
6. Guaiac: Used to detect occult blood in stool.
7. Chemical analysis: A way of looking for a substance present in a specimen.
8. Culture: A mass of micro-organisms growing in a laboratory media or in food.
9. Hemorrhage: Abnormal internal or external loss of blood.
10. Diarrhea: Frequent passage of watery bowel movement.

Exercise

Directions: Match the following words with the correct definitions by putting the letter of the definition in the space provided. Check your answers with the preceding information.

1. Parasite ________
2. Ova ________
3. Bacteria ________
4. Barium ________
5. Occult blood ________
6. Chemical analysis ________
7. Culture ________
8. Hemorrhage ________
9. Diarrhea ________
10. Guaiac ________

a. A mass of micro-organisms growing in a laboratory media or food.

b. The abnormal discharge of pus.

c. Used to detect occult blood in stool.

d. An organism that lives and feeds off the patient.

e. A dye used to visualize arteries on x-rays.

f. Micro-organisms - may or may not be disease producing.

g. Frequent passage of watery bowel movement.

h. A metallic element used to visualize the gastrointestinal tract in x-rays.

i. Abnormal loss of blood.

j. A way of looking for a substance in a specimen.

k. Eggs.

l. Hidden blood.

LEARNING ACTIVITIES - continued

ACTIVITY #2. Stool Specimens

Directions: Read the following information.

The physician may order that a stool be collected from the patient to assist in making a correct diagnosis.

The doctor may order:

1. A stool for culture. Diarrhea may be caused by certain bacteria. If the physician orders a stool for culture, she may be trying to find out what specific bacteria is causing this patient's diarrhea. When she knows which bacteria is causing the diarrhea, the patient can be started on medication that will kill that particular bacteria.
2. A stool for ova and parasites. Parasites such as tapeworms live and feed off the patient. The parasites and ova, or eggs, are often excreted in the stool.
3. A stool for occult blood or for guaiac. If a patient is hemorrhaging from the stomach or from his intestinal tract, the blood can be detected in the stool by chemical analysis.

A stool specimen must be obtained before the patient has any tests that may interfere with or change the stool being tested. For example, castor oil given to prepare patients for tests and barium used to help visualize the gastrointestinal tract for upper G.I. and barium enema x-rays, will change the stool the patient excretes. DO NOT COLLECT a stool specimen if the patient has had recent barium x-rays.

Procedure for Collecting Stool Specimens

Directions: Read the following procedure and answer the questions on collecting stool specimens. You will be asked to demonstrate this procedure as you care for patients in the health care facility. Your instructor will check off these steps as you accomplish them.

PROCEDURE: COLLECTING STOOL SPECIMENS	DEMONSTRATION/COMMENTS
1. Collect equipment: bedpan, patient-name label, a specimen container, tongue blades. If the specimen is for culture, the tongue blades and the container must be clean.	1. ____________________
2. Inform the patient that the doctor has ordred that a stool specimen be collected. Ask the patient to notify the nurse when she is ready to have a bowel movement and to use the bedpan to obtain the stool.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: COLLECTING STOOL SPECIMENS	DEMONSTRATION/COMMENTS
3. When the patient has had a stool, use the tongue blade to scrape off the top portion of the stool (not the portion touching the bedpan) and put it into the specimen container.	3. ________________
4. Label the specimen with: a. the patient's name b. the room number c. hospital number d. date and time e. physician's name f. test ordered	4. ________________
5. Take the stool specimen to the laboratory IMMEDIATELY. Stool specimens for ova and parasites must be examined while still warm so that the motion of the parasites can be seen through a microscope. Stool specimens for culture must immediately be refrigerated.	5. ________________
6. Report to the nurse in charge the time collected, the test ordered, and the number of specimens obtained.	6. ________________

Exercise 1.

Directions: Answer these questions by filling in the blanks or by circling TRUE or FALSE. Answers may be found in the preceding information.

1. A stool specimen for culture is done to determine what ________________ is in the stool.
2. You need a sterile specimen container to collect a stool for culture.

   TRUE FALSE

3. __________ are the eggs.
4. If a patient is hemorrhaging from the stomach, the physician might order a stool for occult blood or for ____________________.

LEARNING ACTIVITIES - continued

5. If a patient had a barium enema in the morning, the stool you collect in the afternoon is O.K. to send as a specimen if it does not look too white.

   TRUE FALSE

6. Tongue blades are equipment used in obtaining stool specimens.

   TRUE FALSE

7. A stool for ova and parasites needs to be refrigerated immediately.

   TRUE FALSE

8. You have collected a stool for culture. List the seven things included on the label before sending the specimen to the laboratory.

   a. ____________ d. ____________ g. ____________

   b. ____________ e. ____________

   c. ____________ f. ____________

Procedure for Developing and Reading Hemoccult Slides

Directions: Read the following procedure and answer the questions on testing a stool specimen for occult blood. The physician's order may read: hemoccult stools, guaiac stools, or check stools for occult blood. These three tests are one in the same. You will be asked to demonstrate this procedure as you care for patients in the health care facility.

PROCEDURE: HEMOCCULT SLIDES	DEMONSTRATION/COMMENTS
1. Collect equipment: bedpan or sani-pan, applicator (wooden), slide, bottle of developer.	1. ____________
2. Inform the patient that the doctor has ordered a stool specimen be checked for blood. Ask the patient to notify the nurse when ready to have a bowl movement and to use the bedpan or sani-pan.	2. ____________
3. When the patient has had a stool, open slide - use the applicator and apply thin smear of stool on guaiac paper inside circle or Box A.	3. ____________

LEARNING ACTIVITIES - continued

PROCEDURE: HEMOCCULT SLIDES	DEMONSTRATION/COMMENTS
4. APPLY second smear from different part of stool inside Box B.	4. ____________________
5. Close slide. Protect from heat and light.	5. ____________________
6. Open perforated window(s) in back of slide.	6. ____________________
7. Apply one (1) drop of water on each section or circle.	7. ____________________
8. Apply two (2) drops of developing solution on each section or circle.	8. ____________________
9. Read results after 30 seconds. THIRTY-second reading time is important, because color reaction will fade after two to four minutes time.	9. ____________________
10. If any trace of blue is seen, the test is positive for occult blood.	10. ____________________

Exercise 2.

Directions: Answer the following questions by circling TRUE or FALSE. Answers may be found in the preceding information.

1. To check a stool for blood, a doctor may order "guaiac stools."

   TRUE FALSE

2. Hemoccult stools, guaiac stools, or check stools for occult blood are one in the same test.

   TRUE FALSE

3. After applying a smear of stool on guaiac paper, apply three (3) drops of water.

   TRUE FALSE

4. You may read the results of the tests in 60 seconds.

   TRUE FALSE

5. If any trace of blue is seen on the guaiac paper, the test is positive for occult blood.

   TRUE FALSE

LEARNING ACTIVITIES - concluded

Exercise 3.

Directions: Take your module to your instructor and then demonstrate the following procedures:

a. Collecting stool specimens

b. Developing and reading hemoccult slides

NURSING ASSISTANT SKILLS

Module D6 - Gastrointestinal Intubation

RATIONALE

Many patients have gastrointestinal tubes inserted for various reasons. As a nursing assistant, you will be required to care for these patients and should know what to observe for and how to make your patient more comfortable.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate nursing care for patients with various types of gastrointestinal: testing, drainage, suction and feeding.
2. Describe the color, amount, and consistency of the output of patients with drainage tubes.
3. Demonstrate feeding a patient with a gastrostomy or enterostomy tube.

LEARNING ACTIVITIES

Directions: Your patient care duties will be determined by the nursing assistant job description of your health care facility. You will be asked to demonstrate the procedure for caring for your patient with a gastrostomy tube and feeding the patient with gastric gavage.

ACTIVITY #1. Reasons for and Types of Gastrointestinal Tubes

Directions: Read the following.

Gastrointestinal intubation is the insertion of a specified tube through the nose (naso) or throat into the stomach (gastro) or the intestine for the following reasons:

1. To drain the stomach or intestinal tract by means of some kind of suction apparatus. It is used to prevent postoperative vomiting, to prevent postoperative obstruction (blocking) of the intestinal tract, and to prevent gas formation in the stomach or intestine.
2. For diagnosis - gastric analysis.
3. To wash out the stomach contents (after taking a poison).
4. To provide a route for feeding one who is unable to take food by mouth.

LEARNING ACTIVITIES - continued

Most Common Gastrointestinal Tubes

1. Cantor Tube - A single long tube used for intestinal decompression. It has a mercury-weighted balloon at its distal tip to assist in stimulating peristalsis and moving the tube into the intestine.
2. Ewold Tube - A specific rubber tube with a large lumen passed through the mouth and down the esophagus to the stomach to withdraw stomach contents for lab exams.
3. Levin Tube - A long plastic or rubber single lumen tube inserted through the nose or mouth to the stomach and used to drain off stomach fluids and to keep the stomach decompressed (free of gas).
4. Miller-Abbott - The most common double lumen rubber tube used to drain or decompress the small intestine. It has an inflatable rubber bag on the distal end which helps stimulate peristalsis, when in small intestine.

ACTIVITY #2. G.I. Drainage Without Suction

Directions: Read the following.

1. Penrose drain is a flat, soft rubber drain. One end is inserted into the designated site by a physician using strict aseptic technique, the free end of the tube rests on the skin, held in place with a stitch or safety pin. The tube is covered with a sterile dressing. Care is taken not to dislodge the tube. Careful observation of amount, color, odor and consistency of drainage should be reported to the nurse in charge.
2. T-tube is a rubber drain used to drain bile from the liver into the intestine. It may be attached to external drainage with a tubing bag system. Care is taken not to dislodge it. The drainage bag is emptied q8h and recorded.
3. Urethral catheters may be used to drain surgical incisions. Care is the same as above.

ACTIVITY #3. Drainage with Suction

Directions: Read the following.

The various types of drainage with suction are:

1. Portable electric suction machine
2. Wall suction unit
3. Gomco Thermotic Pump
4. Two bottle water displacement system
5. Anderson suction

LEARNING ACTIVITIES - continued

Your responsibility will be to see that (1) the suction machine is operating satisfactorily, (2) the machine is plugged in and attached to the patient, and (3) the machine is turned on and the tubes are not kinked. If the machine is not working, report STAT! You will empty contents of drainage bottle q8h, measure, describe, and record.

ACTIVITY #4. Caring for the Patient with a Gastrostomy Tube

Directions: Read the following.

Your patient care responsibilities will include the following:

1. explanation and support to your patient
2. thorough and frequent mouthcare (hopefully with toothbrush)
3. nosecare (cleanse and lubricate nostril)
4. offering patient ice chips, throat lozenges, hard candy or gargles to soothe the throat irritation from the tube at the back of the throat (with doctor's permission)
5. providing for freedom of movement by securing the suction tubing to the clothing and taping the tube to patient's face
6. seeing that the patient does not lie on the tubing or allow the tubing to be kinked.

ACTIVITY #5. Irrigation of NG Tube

Procedure for Irrigation of NG Tube

Directions: Read the following and demonstrate for your instructor.

An LPN may irrigate a NG (nasogastric) tube to keep the lumen open for drainage. The nasogastric tube also prevents gas from accumulating in the stomach.

PROCEDURE: IRRIGATION OF NG TUBE*	DEMONSTRATION/COMMENTS
1. Assemble equipment; clean aspirating syringe, irrigating solution and receptacle.	1. ____________________
2. Disconnect tube from suction machine.	2. ____________________

*Doctor orders specific time intervals or PRN amount and kind of solution.

LEARNING ACTIVITIES - concluded

PROCEDURE: IRRIGATION OF NG TUBE	DEMONSTRATION/COMMENTS
3. Check tube to see if tube is positioned in the stomach. This can be done by injecting air into the tube and listening with a stethescope over the stomach area as the air leaves the tube. The end of the tube can also be inserted in a glass of water. If bubbles appear, the tube is not in the stomach.	3. ______________________
4. Attach filled syringe to free end of levin tube and gently inject the ordered amount of solution and then withdraw fluid. Do Not Force. If fresh bleeding is present, STOP. Notify doctor.	4. ______________________
5. Measure amount of injected fluid and withdrawn fluid and observe contents and record on I & O Sheet. Note if NG tube is in intestine, you may not get returns.	5. ______________________
6. Remove syringe from the tube and attach tube to suction. Check operation of machine.	6. ______________________

NOTE: Nursing assistants will not be responsible for the irrigation.

NURSING ASSISTANT SKILLS

Module D7 - Colostomy Care

unit 8

RATIONALE

A colostomy is the opening between the abdominal wall and the colon through which stool passes. Colostomys will need care while the patient is in a health care facility. The information in this packet will help you care for the patient with an ostomy.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Define terms pertaining to colostomys.
2. Demonstrate the application of a colostomy.
3. Demonstrate the irrigation of a colostomy.

LEARNING ACTIVITIES

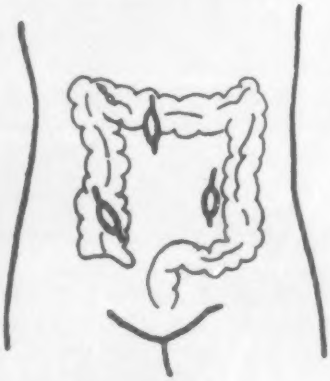
Directions: Read the information and answer all the questions. You will be asked to watch the Trainex called "Colostomy Care" and demonstrate the skills learned in this module to your instructor.

ACTIVITY #1. Definitions of Terms Concerning Colostomy

Directions: Read the following.

A colostomy is a surgically formed opening in the colon (large bowel) through the abdominal wall for the drainage of fecal matter. Colo is a prefix for colon and ostomy is a suffix for opening, thus an opening into the colon.

The reasons for this type of surgery may be cancer of the bowel, intestinal obstruction, or a trauma such as a gunshot wound in the abdomen. The diagram below shows where a colostomy might be placed.



LEARNING ACTIVITIES - continued

Several terms you should know when caring for colostomys are:

Stoma:	Artificially created opening in the bowel which is brought to the surface of the body.
Excoriated:	Irritation found around the stoma.
Irrigation:	Flushing out of the bowel with soapy water.
Karaya:	Medication used to help prevent irritation around the stoma.
Obstruction:	Blocking of the bowel which prevents it from functioning properly.

ACTIVITY #2. Care of a Colostomy

Directions: Read the following information and view the Trainex, "Colostomy Care".

Keeping the patient clean is a constant problem. At first, the stoma or opening, constantly drains soft or liquid stool. Frequent changing of the dressing or frequent emptying of the plastic bag is necessary, day and night, to keep the patient as clean as possible, to control odors, and to prevent breakdown of the skin around the stoma. Clean rather than sterile technique is used because the opening is into the bowel, which normally contains many bacteria.

Wash your hands carefully before and after the changing of the dressing. Collect all the needed equipment first, so that you will not have to obtain supplies from cupboards or from the dressing care while the dressing change is in progress. If you should require additional supplies, wash your hands thoroughly before leaving the patient's unit.

It is convenient to keep all necessary supplies at the patient's bedside, replenishing them as they are needed. The supplies include newspapers or plastic bags for wrapping soiled dressings, extra dressings or plastic colostomy bags, and any medication that has been ordered for the patient's skin.

Remove the plastic colostomy bag or the soiled dressings and dispose of them in plastic bags. Gently wash the skin around the stoma with mild soap and warm water. Gauze fluff usually is used for cleansing. If the skin is inflamed, use water without any soap. Wash gently and thoroughly. Since the skin is very easily irritated, avoid any rubbing.

Work neatly. Avoid leaving soiled articles within the patient's view. Wrapping the soiled dressings in a paper bag as soon as they are removed helps to control odor as well as to make the entire procedure more acceptable to the patient. Provide adequate ventilation, but do not chill the patient. Room deodorizers may be helpful.

Various preparations may be ordered by the physician to treat or to prevent excoriation of the skin. Petrolatum gauze, aluminum powder or paste, Karaya powder, or aluminum hydroxide gel (Amphojel) commonly are applied to the skin around the stoma. Whatever preparation is used, it is important to remove it periodically and observe the condition of the skin underneath.

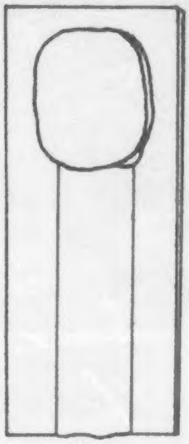
LEARNING ACTIVITIES - continued

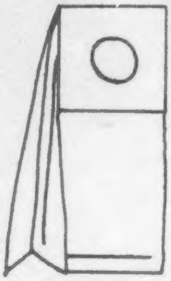
Apply the plastic colostomy bag snugly to minimize leakage. The adhesive that holds the bag against the skin will not stick unless the skin is clean and dry. Apply the bag with the adhesive side down. Apply it smoothly, avoiding any wrinkles. If the patient is ambulatory, the plastic bag may be supported and held more securely in place by an elastic belt made especially for this purpose.

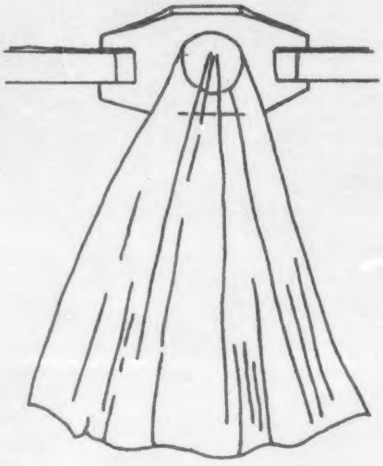
Change everything that is soiled including the gown and the bedding.

Try to change the dressing one-half hour before meals. Changing it too close to mealtime, or serving the tray when the dressing is soiled, may interfere with the patient's appetite.

Below are three types of disposable colostomy bags you might use.







Exercise.

Directions: Now write the definitions for the following words. Answers can be found in the preceding information.

1. Stoma: ____________________

2. Colostomy: ____________________

3. Excoriated: ____________________

4. Ostomy: ____________________

LEARNING ACTIVITIES - continued

5. Irrigation: ____
   ____

6. Obstruction: ____
   ____

7. Karaya: ____
   ____

Procedure for Changing a Colostomy Bag

Directions: Now demonstrate the procedure for your instructor. Your instructor will check off these steps as you accomplish them.

PROCEDURE: CHANGING A COLOSTOMY BAG	DEMONSTRATION/COMMENTS
1. Wash hands and assemble equipment.	1. ____________________
2. Identify patient, explain procedure, and screen.	2. ____________________
3. Drape patient to expose only abdomen.	3. ____________________
4. Remove soiled bag and place in a disposable container.	4. ____________________
5. Wash around stoma with soap and water. Then rinse and pat dry.	5. ____________________
6. Obtain clean bag, peel off adhesive backing, and place over stoma. (May need additional reinforcement and a belt to hold bag in place.)	6. ____________________
7. Change bag as necessary (P.R.N.).	7. ____________________
8. Make patient comfortable and clean up equipment.	8. ____________________
9. Wash hands, report and record observations.	9. ____________________

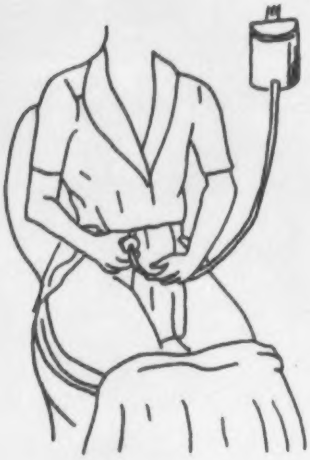
LEARNING ACTIVITIES - continued

Colostomy Irrigation

Directions: Read the following.

Patients with a colostomy often give themselves daily irrigations to establish evacuation at a regular time each day. Some patients continue to require a daily irrigation to empty the bowels and to avoid fecal drainage at other times of the day. Others, especially those with a sigmoid colostomy, find that regular evacuation can later be carried out without irrigation, and that no leakage of feces occurs between evacuations. The irrigations should be done at the same time each day - preferably at the time of the day when the patient will find it convenient to do it at home. If the time is carefully chosen, the schedule of evacuation established in the health care facility will not have to be changed when the patient goes home. Also, if the irrigation is done properly, the patient can eventually wear a small dressing over the stoma and not a bag.

Irrigating a Colostomy



Procedure for Colostomy Irrigation

Directions: Now demonstrate this procedure for your instructor following these steps. Your instructor will check them off as you accomplish them.

PROCEDURE: COLOSTOMY IRRIGATION	DEMONSTRATION/COMMENTS
1. Wash hands and assemble equipment.	1. ______________________
2. Identify patient, explain procedure, and reassure patient.	2. ______________________

LEARNING ACTIVITIES - concluded

PROCEDURE: COLOSTOMY IRRIGATION	DEMONSTRATION/COMMENTS
3. Prepare irrigation solution (500 cc's T.W.) lukewarm water.	3. ____________________
4. Remove air from tube and clamp. Hang colostomy irrigation bag on I.V. pole. (Bag 12-18" above body)	4. ____________________
5. Lubricate tip of tube and insert tube 1 1/2" into stoma. Do not force tube. Notify the nurse in charge if unable to insert tube.	5. ____________________
6. Put open end of colostomy bag in bedpan or if patient is up, in the toilet.	6. ____________________
7. Run no more than 500 cc's of solution into patient's stoma slowly and check for cramping.	7. ____________________
8. Wait 20 - 30 minutes before attaching colostomy bag.	8. ____________________
9. Clean, wash, and pat dry stoma area.	9. ____________________
10. Attach colostomy bag to stoma (hold skin taut). Clamp end of bag.	10. ____________________
11. Make patient comfortable.	11. ____________________
12. Clean up equipment, wash hands, and record, then report to the nurse in charge.	12. ____________________

NOTE: NEVER IRRIGATE AN ILEOSTOMY. An ileostomy is an opening into the small intestine and will drain a liquid fecal material since the stool will not have had a chance to form.

NURSING ASSISTANT SKILLS

Module E1 - Intravenous Therapy

unit 8

RATIONALE

Intravenous therapy (called I.V. therapy) is the administration of fluids into the patient's veins. Patients receive intravenous therapy for a variety of reasons. As a member of the health team, you will be expected to observe the progress of the intavenous infusion and to report any changes to the nurse in charge immediately.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the reasons why a patient may need intravenous therapy and nursing procedures during intravenous therapy by answering questions.

2. Demonstrate the care which should be given to a patient receiving intravenous therapy.

LEARNING ACTIVITIES

Directions: Read all of the information and answer the questions. You will be asked to view the Trainex, Nursing Care During Intravenous Therapy. Remember, ask your instructor to help you if you need it.

ACTIVITY #1. Intravenous Therapy

Directions: Read this information.

Intravenous therapy is the administration of fluids into the vein, intra = into and venous = vein. Usually the doctor or the nurse will start the infusion by inserting a needle through the skin into a vein close to the surface of the skin. Once inserted, the needle is taped in place. Some patients, especially those who are very sick or in shock, do not have any veins close to the skin surface. The physician may then surgically cut through the skin to find a deeper vein and insert a small catheter into the vein for infusion therapy. This catheter is held in place by sutures (stiches) and the incision site is covered by a small sterile dressing. This type of I.V. is called a "cut down". Remember, all intravenous therapy is administered into the vein, never an artery.

A patient may need I.V. therapy to:

1. Supply extra fluids where the normal intake is low, such as for pre- and post-operative patients on restricted diets.

2. Supply extra fluids where the fluid output is greater than normal as for those patients suffering from burns, vomiting, and diarrhea.

LEARNING ACTIVITIES - continued

3. Counteract shock where the patient has lost a large amount of blood.

4. Supply the body with additional nutrients, as glucose.

Once the I.V. has been started, constant and alert observation and reporting are essential throughout the intravenous therapy to prevent the interruption of the flow. Some observations you will be responsible for include:

1. Watch the patient and the response to the therapy. Is the patient experiencing any unusual discomforts such as headache, dizziness, difficulty breathing or nausea? These may be signs of reaction to the medication in the I.V. fluid or may be because the patient is receiving too much fluid for his system. Any unusual symptoms should be reported to the nurse in charge.

2. If the needle has been inserted in the patient's hand, the hand should be kept straight. Assist in maintaining the patient's arm in a comfortable position by taping the hand to the armboard, padding any pressure points, and exercising the fingers and the elbow.

3. Make sure the patient is never lying on the I.V. tubing. Watch for and straighten out any kinks that may form in the tubing as the patient changes position. Pressure or kinks could stop the flow of the solution. DO NOT TAKE A BLOOD PRESSURE IN AN ARM WITH AN I.V. UNLESS IT IS AN EMERGENCY.

4. Check the rate of the flow and the level of the fluid in the I.V. bottle. The rate of flow is prescribed by the physician and will be regulated by the nurse in charge. The flow rate is ordered by the doctor in cc's per hour. To check the rate, count the drops that fall into the plastic drip chamber for one minute. Report to the nurse in charge immediately if the following occurs:

   a. you cannot see drops of solution passing from the bottle into the drip chamber when there is still some solution in the bottle.

   b. when the drip chamber is filled with solution.

   c. when all of the solution has run out of the bottle (NEVER let that happen!) or when the bottle is almost empty.

5. Inspect the needle site every hour and report to the nurse in charge immediately if the following occurs:

   a. when you see blood in the tubing near the needle.

   b. if the patient complains of pain or tenderness where the needle is inserted.

   c. when you observe a lumpy, raised, warm or inflamed area on the patient's skin near the place where the needle is inserted. This may mean that the I.V. solution has caused a severe imflammation of the vein or phlebitis. It might also mean that the solution is not running or infusing into the vein, but instead, is running into the tissues under the skin. This condition is called infiltration of an I.V. solution.

LEARNING ACTIVITIES - continued

6. When ambulating a patient with I.V.'s, remember that at all times the I.V. bottle must be higher than the infusion site. Hang the I.V. bottle on a rolling I.V. stand, whenever possible.

Procedure for Changing the Gown of a Patient Receiving I.V. Therapy

Directions: When changing the patient's gown, you must be very careful not to disturb the needle. To change a gown, follow these steps:

PROCEDURE: CHANGING THE GOWN OF A PATIENT RECEIVING INTRAVENOUS THERAPY	DEMONSTRATION/COMMENTS
1. Remove the soiled gown from the free arm.	1. ______________________
2. Then starting at the shoulder of the other arm, gather the sleeve downward to just above the infusion site.	2. ______________________
3. Pass the gown carefully over the site of the needle puncture, along the tubing, and over and off the hand.	3. ______________________
4. With the sleeve still gathered, guide the gown along the tubing to the bottle.	4. ______________________
5. Move your hand along the tubing, through the gathered sleeve and grasp the bottle firmly.	5. ______________________
6. Remove the bottle from the I.V. stand hook.	6. ______________________
7. Use your free hand to lift the gown over and off the bottle.	7. ______________________
8. Rehang the bottle.	8. ______________________
9. Reverse the procedure to put on a fresh gown.	9. ______________________

LEARNING ACTIVITIES - continued

ACTIVITY #2. Nursing Care During I.V. Therapy

Directions: View the Trainex, Nursing Care During Intravenous Therapy. Then answer the following questions below. Answer by filling in the blanks or circling the correct answer. Answers can be found on page 6.

1. Intravenous therapy is the administration of fluids into the ____________________.
2. If the physician needs to cut through the skin to find a deep blood vessel to insert the needle, the I.V. is called a ____________________ ____________________.
3. I.V. therapy is never given to the patient who has hemorrhaged because the fluid would further dilute the blood. TRUE FALSE
4. I.V. therapy may be started to give medications directly into the bloodstream. TRUE FALSE
5. Patient with severe nausea, vomiting, and diarrhea may need I.V. therapy to supply fluids that have been lost. TRUE FALSE
6. Your patient receiving I.V. therapy suddenly has difficulty breathing and has a rapid pulse. You know that this response is probably because he is frightened and the first thing you do is to sit down next to him and try to reassure him. TRUE FALSE
7. The rate of flow for an I.V. is ordered by the physician in (drops per minute) (cc's per hour).
8. When you check the I.V. needle site, you notice that the area is raised and inflamed. This may mean that the I.V. solution has caused a severe inflammation of the vein also know as (thrombosis) (phlebitis) (embolus).
9. When the I.V. solution is running into the tissues under the skin rather than into the vein, the condition is called ____________________ of the I.V.
10. When changing the gown of a patient with an I.V., always remove the gown from the arm with the I.V. first. TRUE FALSE

Exercise.

Directions: Ask your instructor to set the I.V. equipment at the bedside and to tape the I.V. needle to "Mrs. Chase's" hand. Then demonstrate nursing care during intravenous therapy.

You will:

1. Assist your instructor in taping the hand to the armboard.
2. Move "Mrs. Chase" from side to side. Check that she keeps her hand straight to be sure that the tubing is not kinked.

LEARNING ACTIVITIES - concluded

3. Your instructor will regulate the I.V. to infuse at 125 cc's per hour and 80 cc's per hour. Check the rate of flow by counting the drops per minute.
4. Change "Mrs. Chase's" soiled gown to a clean gown.
5. Ask your instructor to answer any questions you may have.

ANSWERS

ACTIVITY #2

1. vein
2. cut down
3. FALSE
4. TRUE
5. TRUE
6. FALSE
7. cc's per hour
8. phlebitis
9. infiltration
10. FALSE

NURSING ASSISTANT SKILLS

Module E2 - Observation for Transfusion Reaction

RATIONALE

A blood transfusion may be needed to replace lost blood, but many people react to a transfusion if the blood is not the same as their own. It will be important for you to know what to look for in a transfusion reaction.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify symptoms of a blood reaction during a transfusion.
2. Identify nursing assistant responsibilities for blood transfusions.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this part of Module E is included. Read the information and answer the questions. If you need help, your instructor is available.

ACTIVITY #1. Blood Types and Cross Match

Directions: Read the following.

Everyone is one of four blood types: A, B, AB, or O. Each type is classified by a laboratory procedure in which a blood sample is mixed with a small amount of special solution. The mixture is stirred and watched for agglutination (clotting). In this manner, depending on the reaction, blood type can be determined. The RH factor (either positive or negative; that is either present or absent) is also determined by a laboratory procedure.

Some types are more common than others.

BLOOD TYPE	INCIDENCE/100 INDIVIDUALS
A	42
B	10
AB	3
O	45
RH +	85
RH -	15

After determining the blood types and the Rh factors of the recipient and potential donors, a "match must be made to determine if the donor's blood is compatible with that of the recipient. These are specialized laboratory procedures.

LEARNING ACTIVITIES - continued

ACTIVITY #2. Blood Transfusion

Directions: Read the following.

As a nursing assistant, you will not be responsible for administering blood; however, you should understand the procedure and know what to look for in case of a transfusion reaction.

Injecting blood is similar in most respects to other types of intravenous therapy. A special consideration is that blood must be kept cooled before administration.

The first step in any transfusion is for the R.N. to check the name and hospital number on the unit of blood against the name and the hospital number on the blood sheet sent up from the lab. Two registered nurses must check this together. Then, before adding the blood to the already infusing I.V., they will check the name and the hospital number on the unit of blood against the patient's name band. This is a must!!!

As a nursing assistant, you may be asked to take the patients temperature before and after the blood is infused. You may be asked to observe the patient closely for at least 15 minutes after the beginning of a transfusion. During this time, the infusion rate should not exceed 20 drops per minute. Following this, the usual observations for parenteral (I.V.) therapy are made.

Exercise 1.

Directions: Complete the following exercise. Check your answers by referring to Unit 8, Module E1.

What are the five observations you should make for an I.V.? List them below.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Transfusion Reaction

A transfusion reaction is a serious complication of a blood transfusion. If incompatible blood is given, a reaction will occur with symptoms evident within ten minutes. The first signs/symptoms you will observe or the patient will complain of will be:

1. chills
2. headache
3. abdominal distress

LEARNING ACTIVITIES - continued

4. increased temperature

5. decreased blood pressure

6. evidence of shock, dyspnea (shortness of breath), and cyanosis (bluish skin)

7. urticaria (hives)

If any of these symptoms occur, notify the nurse in charge immediately. Incompatible blood can cause death!!

Later symptoms you will observe include:

1. small volume of red urine (may progress to uremia)

2. nausea and vomiting

3. weakness

4. pain and diarrhea

5. stupor and death

Recognition of a reaction and prompt treatment can prevent a serious outcome. Discontinue the blood immediately and call the R.N. or the physician.

Nursing Care

Once the blood has been discontinued and the physician has been notified, nursing care consists mainly of keeping the patient comfortable and collecting all of the urine for the next 24 hours. The urine is collected because the reaction releases a toxic substance that causes the vessels in the kidneys to spasm and could eventually cause kidney failure.

Other Transfusion Complications

1. Overloading the heart and/or circulatory system may cause pulmonary congestion (pulmonary edema). Giving too much fluid too fast can cause this especially in elderly patients or in those with heart conditions. Immediate symptoms are restlessness and confusion, then, dyspnea and cyanosis.

2. Infections may be contacted by the recipient if there are disease-causing organisms in the donor's blood. Most common diseases are hepatitis and malaria.

3. Allergic reactions, though uncommon, may be in the form of urticaria (hives) or asthma.

LEARNING ACTIVITIES - concluded

Exercise 2.

Directions: Answer the following questions concerning a blood transfusion.

1. Write the four blood types on the lines below.

    a. ____________________

    b. ____________________

    c. ____________________

    d. ____________________

2. List the seven symptoms you may observe in a transfusion reaction.

    a. ____

    b. ____

    c. ____

    d. ____

    e. ____

    f. ____

    g. ____

NURSING ASSISTANT SKILLS

Module F1 - Oxygen Therapy

RATIONALE

Since both you and your patient need oxygen to live, it will be helpful for you to learn how to recognize your patient's need for oxygen and how to work with the equipment when it is in use. Oxygen can cause fires and is very dangerous if safety precautions are ignored.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Recognize and define terms and abbreviations relating to oxygen therapy.
2. Identify signs and symptoms of oxygen need in a patient.
3. Identify and practice safety precautions when oxygen is being used.
4. Identify the concentration of oxygen delivered by the different methods of oxygen administration.

LEARNING ACTIVITIES

Directions: Read all of the information in this part of Module F and answer the questions at the end of each section. You will be asked to watch the Trainex, Oxygen Administration. Be sure to learn the vocabulary words and the abbreviations before reading the rest of the information. If you have questions, STOP, and ask for help from your instructor.

ACTIVITY #1. Abbreviations and Terms

Directions: Learn the following common abbreviations and terms.

1. O_2 - Oxygen
2. $C0_2$ - Carbon dioxide
3. P.R.N. - as desired or as needed
4. resp. - respiration
5. S.O.B. - short of breath
6. hypoxia - lack of an adequate amount of oxygen in inhaled air
7. apnea - without or the absence of air or breath

LEARNING ACTIVITIES - continued

8. cyanosis - blue discoloration of the skin due to lack of oxygen
9. dyspnea - difficult or painful breathing
10. orthopnea - respiratory condition where breathing is possible only when a person sits or stands in an erect (straight up) position

Exercise 1.

Directions: Give the correct meaning for the following abbreviations in the space provided. Check your answers with the preceding information.

1. O_2 - ______________________________
2. CO_2 - ______________________________
3. P.R.N. - ______________________________
4. resp. - ______________________________
5. S.O.B. - ______________________________

Exercise 2.

Directions: Define the following medical terms. Check your answers with the preceding information.

1. hypoxia - ______________________________
2. apnea - ______________________________
3. cyanosis - ______________________________
4. dyspnea - ______________________________
5. orthopnea - ______________________________

ACTIVITY #2. Symptoms of Oxygen Need

Directions: Read this information.

Symptoms of O_2 need or hypoxia will vary depending on the degree of the oxygen needed. The patient's pulse and respiratory rate usually increase as the need for oxygen becomes greater. He may be dyspneic. If the body's tissues need oxygen, the medulla part of the brain sends a message to the lungs to start breathing faster. Respirations may become rapid, shallow, and irregular. The brain also sends a message to the heart to speed up and to increase the flow of blood carrying oxygen to the tissues. If you look closely, you may notice that the dyspneic patient's skin has a dusky or a bluish color. This cyanosis will be most apparent in the nailbeds, the earlobes, and the lips.

LEARNING ACTIVITIES - continued

Restlessness, anxiety, or irritability are also common symptoms of oxygen need associated with a deficiency of oxygen in the tissues of the brain. Eventually, the patient may become confused and lose consciousness.

The patient knows that life will continue as long as he breathes; therefore, breathlessness is frightening. He signals for help to prevent the death that he thinks is approaching. He is afraid to be alone and he calls you constantly or he may even come out of the room to find you.

Your patient may have a combination of additional symptoms such as sighing, yawning, headache, nausea, vomiting, or dizziness.

Sleeplessness is another symptom experienced when the patient is hypoxic. The patient with extreme dyspnea uses the muscles of the neck, shoulders, and upper arms to help him breathe. You can experience this by running up and down the stairs a few times. Observe your use of these muscles which require conscious effort and the use of more energy which is, therefore, very fatiguing.

When the dyspneic patient falls asleep, the muscles of the neck, shoulders, and upper arms stop helping his respiratory effort and his breathing effectiveness decreases. After only a short period of sleep, the dyspneic patient goes into oxygen want and wakes up frightened, breathless, and gasping for air.

As you care for the dyspneic patient, you must be constantly alert for symptoms of oxygen need or hypoxia and report any symptoms to the nurse in charge immediately.

Exercise.

Directions: Answer these questions by filling in the blanks or by circling the correct word. Check your answers with the preceding information.

1. If a patient is in need of oxygen, the pulse rate will (increase, decrease) and the respiratory rate will (increase, decrease). Respirations will be __________ and __________.

2. What part of the brain controls respirations? ______________________________

3. If a patient has difficult or painful respirations, he is said to be (orthopneic, dyspneic).

4. ______________________ is the bluish discoloration of the skin due to lack of oxygen.

5. When there is a deficiency of oxygen in the tissues of the brain, the patient will become ________________________ or ___________________________ and may eventually become ___________________________ and lose consciousness.

6. Cyanosis is most apparent in what three parts of the body?

   a. ___________________ b. ____________________ c. ______________________

LEARNING ACTIVITIES - continued

7. Explain in your own words, one of the reasons why a patient in need of oxygen is afraid to be alone.

   ____

   ____

8. The nurse in charge has told you that you have a patient with congestive heart failure and to watch for symptoms of oxygen need. List five symptoms you will be looking for in this patient.

   a. ________________________

   b. ________________________

   c. ________________________

   d. ________________________

   e. ________________________

ACTIVITY #3. Caring for the Dyspneic Patient

Directions: Read this material on caring for the dyspneic patient.

The doctor will simplify the dyspneic patient's life so that the respiratory system can support the patient with the least effort. This simplification may include the following:

1. Bedrest.
2. Soft diet so that little effort is required to chew and to digest food.
3. Stool softeners to soften stools and, therefore, decrease the energy required in defecation.
4. Bedside commode for defecation.
5. Tap water for drinking as ice water will narrow the blood vessels and decrease the heart action.
6. Privacy to remove the patient from the excitement and the disturbances of the health care facility.

The nurse will develop a plan of care that makes the patient's living as effortless as possible. In this plan, you will be directed to do many activities for the patient.

LEARNING ACTIVITIES - continued

You can help make the dyspneic patient's living easier by doing the following activities as needed.

1. Reduce the patient's work at living:
    a. Keep the patient on absolute bedrest. Do all the care.
    b. Keep personal articles close by to prevent reaching, stretching, etc.
2. Control pain and discomfort:
    a. Report the patient's complaints of pain to the nurse promptly.
    b. Change the patient's position at two-hour intervals.
3. Eliminate emotional distress:
    a. Prevent feelings of helplessness and fear by your caring and comforting presence.
    b. Listen to the patient's problems and help to solve them or report it to the nurse promptly.
    c. Avoid threatening experiences. Explain procedures before doing them.
    d. Make sure the call light is within easy reach and answer the calls promptly. Visit frequently to determine needs so that you will not need to be called.
    e. Stay with the patient in times of severe dyspnea.
4. Conserve the patient's energy:
    a. Assist onto the bedside commode and off again.
    b. Give drinks that are neither hot nor cold.
    c. Follow the nurse's directions for bathing and positioning of the patient. These procedures may need to be modified or even eliminated if they use up the energy that the patient needs to breathe.
    d. Plan for periods of rest between periods of activity. Work slowly. Do not hurry.

You can make the patient's breathing easier by doing the following:

1. Position the patient in a semi-sitting position (Fowler's). In this position, gravity pulls the abdominal contents (bowels, stomach, etc.) away from the diaphragm and permits the diaphragm to move easily. This position also pulls fluid (pulmonary edema or infection-like pneumonia) to the bottom of the lung and frees the remaining lung space for breathing.

LEARNING ACTIVITIES - continued

2. Free the patient's chest from the splinting effect of the bed. Place an overbed table in position in front of the patient to lean on (orthopneic position). Teach the patient to use the arms for support.

3. Change the patient's position frequently, if permitted. This rotates pressure-bearing and lung-splinting areas and helps to avoid not only decubitus ulcers, but, also eliminates the respiratory complications of bedrest. Protect weight-bearing buttock areas with lamb's wool mats (absorb moisture and equalizes pressure) or sponge, rubber seats (equalizes pressure).

4. Avoid the use of powder and materials with a sharp odor like talcum and alcohol which contaminate the patient's air, irritate the breathing passageways, and increase his breathlessness.

Exercise.

Directions: Answer these questions on caring for the dyspneic patient. Fill in the blanks or circle TRUE or FALSE. Answers to this exercise can be found in the preceding information.

1. The doctor will probably allow the dyspneic patient to "shower - P.R.N." because the warm steam is relaxing and opens the bronchioles to make breathing easier.
   TRUE FALSE

2. The dyspneic patient should be given tap water to drink instead of ice water.
   TRUE FALSE

3. You should change the dyspneic patient's position every (1, 2, 3) hours.

4. List two ways that you may help eliminate emotional distress in the patient with oxygen need.

   a. ____

   b. ____

5. If the patient becomes dyspneic with activity, you would probably give a ________________ bath.

6. If your patient has orthopnea, make breathing easier by positioning her in the ________________________ position.

7. Since powder and sweet smelling lotions contaminate the patient's air and increase breathlessness, you should use alcohol to rub the back.
   TRUE FALSE

LEARNING ACTIVITIES - continued

ACTIVITY #4. Safety Precautions Necessary When Using Oxygen

Directions: Read the following information.

Oxygen therapy is relatively easy to start. However, it is a dangerous treatment because oxygen encourages combustion or burning and can blow a little spark into a huge fire. Eliminate this hazard by doing the following steps.

1. Prepare the patient:
    a. Explain that you are going to give oxygen to assist breathing.
    b. Tell all patients in the same room that smoking is forbidden. Remove cigarettes and matches.
2. Prepare the room:
    a. Hang a "NO SMOKING--OXYGEN IN USE" sign on the door to the room.
    b. Remove all spark-producing, electrical equipment such as electric shavers, heating pads, and radios; and remove all highly inflammable materials such as alcohol and grease.
    c. Place a fire extinguisher outside the door to the room. If a fire extinguisher is not available to place outside the door, find the fire extinguisher that is used on your unit. Find out how it works. Look for the fire alarm.

Exercise.

Directions: Answer these questions. Check your answers with the information above.

1. If the patient is receiving oxygen, smoking is allowed only when the oxygen is turned off and pulled out of the wall.
   TRUE FALSE
2. The nurse in charge tells you that your patient is to receive oxygen and asks you to prepare the room. What three things would you do?
    a. ______________________________
    b. ______________________________
    c. ______________________________
3. Why are safety precautions necessary when a patient is receiving oxygen?

____

____

____

____

LEARNING ACTIVITIES - continued

ACTIVITY #5. Oxygen Administration

Directions: Delivery of oxygen is explained in the Trainex, Oxygen Administration. Answer the questions below as you watch the Trainex by filling in the blanks or by circling TRUE or FALSE. The answers can be found on page 10.

1. When oxygen administration is prescribed, the doctor will order the concentration of oxygen, whether therapy is to be continuous or intermittent or PRN, and the method of adminstration. TRUE FALSE

2. What does "PRN" mean? ________________________________

3. List four methods of administration of oxygen.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

4. Which method of administration is used when the patient requires only a medium concentration of oxygen?

5. Which method of administration is used when the patient requires low concentration of oxygen?

6. When using wall outlets to deliver oxygen, a ____________________ is attached to the outlet to control the rate of oxygen flow to the patient.

7. The rate of flow of oxygen will be measured in _____ per minute.

8. Because oxygen is drying to mucus membranes, the flowmeter will have a humidifier attached to it to moisturize the oxygen as it bubbles through the water. TRUE FALSE

9. The humidifying bottle is filled with __________________ ____________ to the indicated mark or about (3/4, 1/4, 1/2) full if there is no mark.

10. When oxygen therapy is discontinued, you should turn the flowmeter off and unplug it by pulling it out of the wall.
    TRUE FALSE

11. Nasal catheters are designed to be inserted through the patient's nostrils down into the trachea to deliver a high concentration of oxygen.
    TRUE FALSE

12. A nasal catheter should be taped to the patient's nose and cheek after insertion.
    TRUE FALSE

LEARNING ACTIVITIES - concluded

13. The rate of flow usually prescribed for oxygen administration through a nasal catheter is from ___________ to __________ __________ per minute.

14. The nasal ______________ is another method of adminstration of oxygen; two short tubular prongs extend into the nostrils.

15. Oxygen tents are the most frequently used method of administration oxygen because they deliver a very high concentration of oxygen.
TRUE FALSE

16. When a patient is receiving oxygen by tent, you must be very careful to prevent leakage of oxygen by tucking the canopy under the mattress and by opening the tent only when necessary. TRUE FALSE

17. When a low medium concentration of oxygen is ordered, a ________________ may be used to administer oxygen.

18. The average rate of flow of oxygen administered using a face mask is from _______ to _____________ ___________ per minute.

19. The oxygen mask should fit snugly so that oxygen does not blow into the patient's eyes. TRUE FALSE

20. The oxygen mask should be removed every ___________ hours or more often as desired by the patient to sponge off the face.

ANSWERS

ACTIVITY #5

1. TRUE
2. whenever necessary
3. a. mask
   b. nasal catheter
   c. nasal cannula
   d. tent
4. mask
5. cannula
6. flowmeter
7. liters
8. TRUE
9. distilled water, 1/2
10. TRUE
11. FALSE
12. TRUE
13. 2 to 6 liters
14. cannula
15. FALSE
16. TRUE
17. tent
18. 5 to 10 liters
19. TRUE
20. 2

unit 8

NURSING ASSISTANT SKILLS

Module F2 - Sputum Specimen Collections

RATIONALE

The physician may order that sputum be collected from the patient for examination to assist in making the diagnosis of a disease. To help make an accurate diagnosis, you must know the correct procedure used for the collecting of sputum.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Recognize definitions and match with words relating to sputum specimens.
2. Demonstrate and answer written questions on the procedure for collection of a sputum specimen.
3. Recognize the reasons for examination of sputum specimens.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this part of Module F is included. Be sure to learn the vocabulary words before reading the rest of the material. Answer all questions. You will be asked to demonstrate collecting sputum specimens as you care for patients. If you need help, your instructor is available.

ACTIVITY #1. Vocabulary Words

Directions: Learn these vocabulary words.

1.	Sputum:	Expectorated bronchial secretions that occur when there is irritation or disease involving the trachea, bronchi, or lungs.
2.	Bacteria:	Micro-organisms; some may cause disease and others may not.
3.	Culture:	A mass of micro-organisms growing in a laboratory media or food.
4.	Acid fast:	A specific test done to detect acid fast bacteria (used in tuberculosis).
5.	Cytology:	The examination of cells; a test usually done to detect cancer cells.

LEARNING ACTIVITIES - continued

Exercise.

Directions: Match the following words with the correct definitions by putting the letter of the definition in the space provided. Check your answers with the preceding information.

1. Sputum ______
2. Bacteria ______
3. Culture ______
4. Acid fast ______
5. Cytology ______

a. A way of looking for a substance in a specimen.

b. Micro-organism.

c. Examination of cells usually done to detect cancer.

d. A mass of micro-organisms growing in a laboratory media or food.

e. A test done to detect blood.

f. Expectorated bronchi secretions.

g. A test done to detect acid fast bacteria.

ACTIVITY #2. Sputum Specimens

Directions: Read the following information.

The physician may order that a sputum be collected from the patient to assist in making the diagnosis of a disease. Repeated examinations of sputum may be ordered on successive days. The patient should be instructed to raise the sputum with a deep cough from the chest and not from the mouth. A sputum specimen should not contain saliva. Frequently, the patient is asked to collect the specimen early in the morning because the sputum produced then is usually from deep in the bronchi. If the patient has difficulty producing sputum, the physician may order that it be induced by Inhalation Therapy (breathing treatments which help to expand the lungs).

The physician may order:

1. A sputum for culture. A sputum for culture will help the physician know what specific bacteria is causing the patient's lung disease.

2. A sputum for acid fast. An acid fast test is a specific test done in which the bacteria in the sputum retains a red dye in spite of the acid-alcohol which removes the color from everything else. Bacteria retaining the red stain are said to be acid fast. An example of bacteria that is acid fast is the bacteria that causes tuberculosis.

3. A sputum for cytology. Cytology is the examination of cells as they are sloughed off by the body. If cancer is present, the cancer cells will also be sloughed off and a diagnosis of cancer can be made. The sputum specimen is placed in a special fluid usually referred to as "cytology fluid" that helps to fix the cancer cells so that they may be more easily identified under a microscrope.

LEARNING ACTIVITIES - continued

Procedure for Collecting Sputum Specimens

Directions: Read the following procedure. You will be asked to demonstrate the procedure as you care for patients in the health care facility. Your instructor will check off these steps as you accomplish them and make comments as to how well you performed them.

PROCEDURE: COLLECTING SPUTUM SPECIMENS	DEMONSTRATION/COMMENTS
1. Collect equipment: a sterile, wide-mouthed container.	1. ____________________
2. Inform the patient that the doctor has ordered that a sputum specimen be collected. Instruct her to brush the teeth and to clean the mouth so that no saliva or old food particles are expectorated.	2. ____________________
3. Place the patient in a sitting position. If coughing is inhibited by pain, have her lie on the affected side to help splint the chest. Encourage the patient to breathe and cough deeply. Expectorate sputum directly into the sterile container.	3. ____________________
4. Label the specimen with: the patient's name, hospital number, physician's name, room number, date and time, and test ordered.	4. ____________________
5. Take the specimen to the laboratory IMMEDIATELY. The sputum for cytology must be fixed in cytology fluid or the specimen is worthless. Sputum specimens for culture must be refrigerated.	5. ____________________
6. Report to the nurse in charge the time collected and the test ordered.	6. ____________________

LEARNING ACTIVITIES - concluded

Exercise.

Directions: Answer these questions by filling in the blanks or by circling TRUE or FALSE. Answers can be found in the preceding information.

1. A sputum specimen for culture is done to determine what ________________ is in the sputum.

2. You do not need a sterile container to collect a sputum for culture since the secretions are already contaminated with bacteria.
   TRUE FALSE

3. Since the sputum will contain many disease-producing bacteria, you should wear gloves to collect the specimen. TRUE FALSE

4. If your patient has a diagnosis of possible tuberculosis, the physician will probably order a sputum for ______________________ ________________________.

5. A sputum for ________________________ is usually ordered when the patient has possible cancer.

6. A specimen collected in the early morning is usually best because the sputum produced then is from deep in the bronchi. TRUE FALSE

7. You have collected a sputum for cytology. List the seven things that are included on the label before sending the specimen to the laboratory.

   a. ____________________________________

   b. ____________________________________

   c. ____________________________________

   d. ____________________________________

   e. ____________________________________

   f. ____________________________________

   g. ____________________________________

NURSING ASSISTANT SKILLS

Module G1 - Foley Catheter

RATIONALE

As a nursing assistant, you will be caring for many patients with Foley catheters. They are used to drain the urine out of the bladder. This part of Module G will help you to know how to care for a patient with a catheter.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate knowledge of care which should be given to a patient with a Foley catheter.
2. Identify three types of urinary catheters and when each is used by answering written quesitons.
3. Demonstrate the emptying of the Foley Bag including measuring and recording output.

LEARNING ACTIVITIES

Directions: This is the first part of Module G. There are seven parts to Module G so do not waste any time!! Read all of the information and answer the questions. You will be asked to view a Trainex on Urinary Care. If you need any help, ask your instructor.

ACTIVITY #1. Caring for the Patient with a Foley Catheter

Directions: Read this material.

The urinary catheter is a sterile catheter inserted into the bladder to drain urine. Usually the catheter is inserted through the urethra. However, if the urethra is obstructed, the physician may need to make a surgical incision through the lower abdomen and into the bladder to insert the catheter; this type of catheter is called a suprapubic catheter.

A urinary catheter is used:

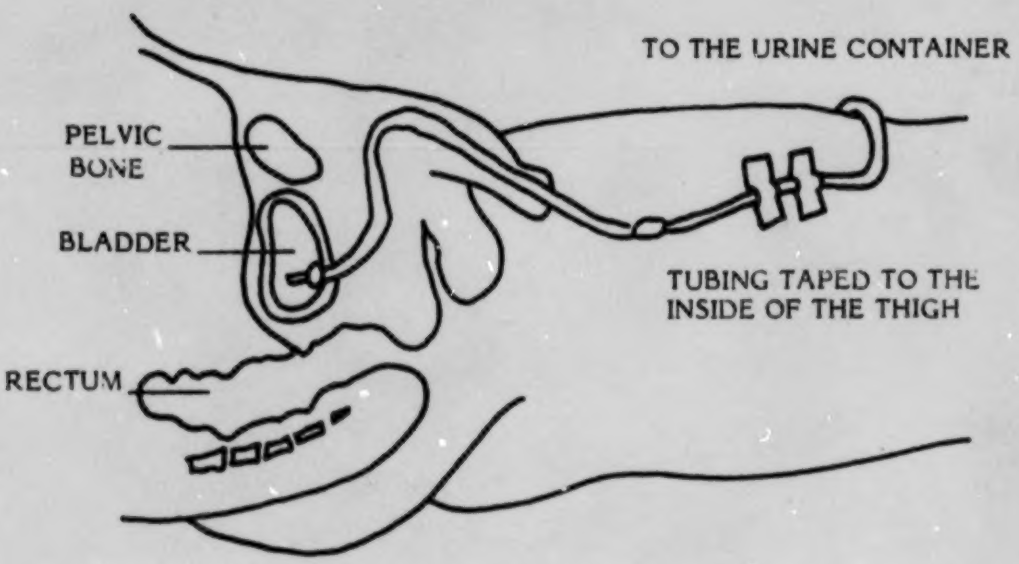
1. To obtain a sterile urine specimen.
2. To measure residual urine (urine left in the bladder after the patient has voided).
3. To relieve retention when the patient is unable to urinate naturally.
4. When the physician expects difficulties in the functioning of the urinary system after surgery.

LEARNING ACTIVITIES - continued

There are two types of catheters most commonly used:

1. the French or straight catheter
2. the Foley or retention catheter

The straight catheter is a plastic or rubber tube that is inserted into the bladder to drain the urine and is immediately removed. This type of catheter would be inserted to obtain a specimen or to empty the bladder one time. The Foley catheter is specially made so that it will stay in place within the bladder. It is made of two tubes, one inside the other. The inside tube is very small and is connected at one end to a balloon. After the catheter has been inserted into the bladder, the balloon is filled with water or air so the catheter is unable to fall out of the bladder. Urine then drains out of the bladder through the outer tube which is then connected to a Foley bag to collect the urine.



THE FOLEY CATHETER

LEARNING ACTIVITIES - continued

When caring for a patient with a Foley catheter, you should observe these rules:

1. Frequently check the catheter and tubing to make sure that they are not kinked and that the patient is not lying on them. Both kinking and pressure may stop the flow of urine out of the bladder.

2. Keep the excess drainage tubing from hanging over the side of the bed by curling it up on top of the bed and securing it with a rubber band and a safety pin. If the tubing is allowed to hang over the side of the bed, the urine will collect in the tubing and not drain properly into the Foley bag.

3. Keep the Foley bag below the patient's bladder at all times so that the urine will drain DOWN out of the bladder (gravity drainage). If the bag is at the same level as the patient's bladder or is above the bladder, the urine will drain out of the tubing and back into the patient's bladder.

4. ALWAYS keep the Foley bag hanging from the bottom frame of the bed. Do not attach it to the side rail. Keep the bag OFF of the floor. REMEMBER, the bladder is a sterile body cavity and bacteria from the floor may travel up into the bag and then into the bladder and cause infection.

5. Check the level of the urine in the Foley bag every hour to be sure the level of the urine goes up. If the level stays the same, report this to the nurse immediately. It may mean that the catheter is plugged and needs to be irrigated.

6. Ask the patient to turn the leg out and tape the catheter to the patient's inner thigh. Be sure to leave enough slack to allow the patient to move without putting any tension on the catheter.

7. Give the patient perineal care at least once during an eight-hour shift. (See Module A - Giving Perineal Care.)

8. Immediately report to the nurse:

   a. if your patient says the bladder is full or that there is a need to urinate. There may be a blockage in the catheter that prevents the urine from being drained out of the bladder.

   b. if your patient complains of burning, tenderness, or pain in the bladder or urethral area. These symptoms may indicate a bladder infection.

Exercise.

Directions: View the Trainex, Urinary Care, and answer the questions by filling in the blanks or by circling TRUE or FALSE. Answers can be found on page 7.

1. One type of catheter, the ____________ or ____________ catheter is inserted into the bladder to obtain a specimen or to empty the bladder one time.

2. Another catheter, the ____________ or ____________ catheter is designed so that it will stay in the bladder.

LEARNING ACTIVITIES - continued

3. What holds this type of catheter in the bladder? ______________________ ___________

4. If the urethra is obstructed, the physician will insert a catheter into the bladder through an incision in the abdominal wall. This type of catheter is a ____________________ catheter.

5. What is residual urine?

6. Catheterization is not necessarily a sterile procedure because urine is acid and will kill bacteria entering the bladder. TRUE FALSE

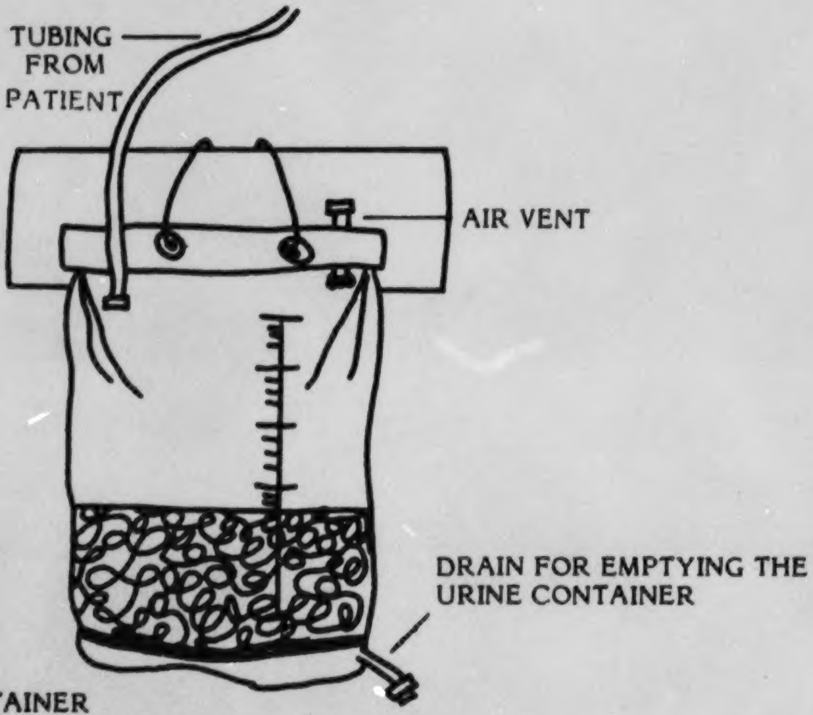
7. How often is perineal care given to the patient with a Foley catheter? _________________________________

8. The only way to obtain a sterile urine specimen is to catheterize the patient. TRUE FALSE

ACTIVITY #2. Emptying the Foley Bag

Directions: Read the following information.

The Foley bag collects the urine that is drained through the Foley catheter from the patient's bladder. It is usually emptied at least once at the end of each eight-hour shift.



PLASTIC URINE CONTAINER HUNG ON THE BED

LEARNING ACTIVITIES - continued

Procedure for Emptying the Foley Bag

Directions: Read the procedure for emptying the Foley bag. When you demonstrate the procedure, your instructor will check off the steps as they are accomplished and make comments on your performance.

PROCEDURE: EMPTYING THE FOLEY BAG	DEMONSTRATION/COMMENTS
1. Collect equipment: clean measuring container.	1. ____________________
2. Empty the drainage tubing so that all the urine in the tubing drains into the Foley bag. Make sure the urine does not flow back into the patient's bladder.	2. ____________________
3. Place the container on a paper towel. Unclamp the drain at the bottom of the Foley bag.	3. ____________________
4. Drain the urine out of the bag into the measuring container.	4. ____________________
5. Reclamp the drain at the bottom of the bag.	5. ____________________
6. Take the measuring container into the patient's bathroom. Place the measuring container on a level surface, at eye level, and measure the amount of the urine collected.	6. ____________________
7. Discard the urine in the toilet and rinse the measuring container with cold water.	7. ____________________
8. Record the amount of urine collected in cc's under the "Output" column in the box for the eight-hour total output on the Intake and Output Record Sheet.	8. ____________________

LEARNING ACTIVITIES - concluded

Exercise.

Directions: Ask your instructor to catheterize "Mrs. Chase", the mannequin, fill the Foley bag with water, and connect the tubing to the catheter. Then demonstrate the procedure and answer these questions. Check your answers with the preceding information.

1. Attach the bag to the bed properly. Why is it important to keep the bag off of the floor? ____________________
2. Fix the excess drainage tubing.
3. Tape the catheter to "Mrs. Chase's" thigh.
4. Turn "Mrs. Chase" from her back to her side. List two things you must watch for when the patient moves in bed.

   a. ____________________ b. ____________________

5. Give "Mrs. Chase" perineal care.
6. Empty the Foley bag and measure the amount obtained.

ANSWERS

ACTIVITY #1

1. French or straight
2. Foley, retention
3. balloon filled with air or water
4. suprapubic
5. urine left in the bladder after the patient voids
6. FALSE
7. at least once during an eight-hour shift
8. TRUE

NURSING ASSISTANT SKILLS

Module G2 - Bladder Irrigations

RATIONALE

You may be asked to care for a patient with continuous bladder irrigations. Read this module to learn how to care for this kind of patient and why this treatment is necessary.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the reasons for a continuous bladder irrigation treatment.
2. Demonstrate and answer written questions on the care which should be given to a patient with continuous bladder irrigations.
3. Demonstrate hanging a bladder irrigation bottle.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete Module G2 is included. Read this material and be sure to answer the questions. There is a section for demonstrating care of the patient with continuous bladder irrigation at the end. If you need help, your instructor is available.

ACTIVITY #1. Continuous Bladder Irrigations

Directions: Read this information.

A continuous Foley irrigation is a continuous washing out of the bladder. A patient may need bladder irrigations. Here are some reasons why.

1. To prevent the accumulation of blood in the bladder.
2. To remove sediment and blood clots that have formed in the bladder in order to prevent the catheter from becoming obstructed or plugged.
3. For continuous addition of medication to the bladder to prevent or fight infection.

The solution most frequently used for continuous bladder irrigations is normal saline. Normal saline solution is a solution of distilled water and sodium chloride or salt. The amount of salt mixed in the water is the same percentage as the amount of salt mixed in blood. Instead of normal saline, the physician may order a special solution for irrigating the bladder that contains medication. Always check the doctor's orders to learn what solution has been ordered.

LEARNING ACTIVITIES - continued

As you care for a patient with continuous bladder irrigation, remember to follow these rules.

1. Frequently inspect the catheter, the irrigation tubing, and the drainage tubing to be sure that they are not kinked and that the patient is not lying on either. Both kinking and pressure may prevent the flow of the solution into the bladder or may stop the flow of urinary drainage out of the bladder.

2. Keep excess drainage tubing from hanging over the side of the bed by curling it up on top of the bed and securing it with a rubber band and a safety pin.

3. Check the rate of flow from the irrigation bottle to the patient by watching the drips as they fall into the plastic drip chamber. Compare that rate with the rate of drips from the drainage tubing as it drips into the collecting bottle. If the patient's urinary drainage is less than the amount of solution going into the bladder, the catheter may be plugged with a blood clot or with sediment. You must report this condition immediately to the nurse in charge.

4. Keep the collecting bottle on the floor below the patient's bladder at all times so that the urine will drain down out of the bladder.

5. Check the output in the collecting bottle for color and report any changes in color to the nurse in charge. If the patient is bleeding from the bladder, the nurse will regulate the rate of flow or the irrigating solution according to the degree of bleeding.

6. Ask the patient to turn the leg outward and tape the catheter to the patient's inner thigh. Be sure to leave enough slack to allow the patient to move without putting tension on the catheter.

7. Give the patient perineal care at least once during your eight-hour shift. (See Module A - Giving Perineal Care.) Give perineal care when there is any urinary drainage leaking from around the catheter.

8. Immediately report to the nurse in charge:

    a. if your patient says the bladder feels full or reports the need to urinate.

    b. if your patient complains of low abdominal cramping or "bladder spasms".

    c. if you notice a leaking of urinary drainage from around the catheter.

    These may all indicate that there is a blockage in the catheter that prevents the urine from draining out of the bladder.

LEARNING ACTIVITIES - continued

Another very important rule to remember: NEVER LET THE IRRIGATION BOTTLE RUN OUT OF SOLUTION. If the irrigation solution is not continuously washing out the bladder, blood clots may form which can obstruct the catheter. When hanging a fresh bottle of irrigation solution, you must be very careful to hang the bottle without getting air into the irrigation tubing. To do this, follow the procedure below.

Procedure for Hanging a Bladder Irrigation Bottle

PROCEDURE: HANGING A BLADDER IRRIGATION BOTTLE	DEMONSTRATION/COMMENTS
1. Close all clamps on the irrigation tubing to prevent air from getting into the tubing.	1. ____________
2. Remove the plastic protector cap from the fresh bottle of irrigating solution and open the bottle.	2. ____________
3. Remove the old irrigation bottle from the pole and unscrew the tubing.	3. ____________
4. Screw the tubing into the new irrigation bottle, invert the bottle, and hang on the pole. Be sure to use aseptic technique. DO NOT touch the inside of the screw cap. REMEMBER: The bladder is a sterile body cavity.	4. ____________
5. Open the clamps and ask the nurse to set the flow rate.	5. ____________

Every time you hang a fresh bottle of irrigation solution, empty the collecting bottle and record the amount of output in cc's under the column labeled "IRRIGATION" on the I & O sheet. ACCURATE OUTPUT IS IMPORTANT!! This is the only way that the doctor can estimate the amount of bleeding from the bladder. At the end of an eight-hour shift, complete the following:

1. Add the cc's of output. (List on the chart under the column labeled Irrigation-Out.)
2. Add the amount of irrigation solution used. (List on the chart under Irrigation-Added.)
3. Subtract the total amount of irrigation solution used from the total amount of output. This is the total urinary output.
4. Record the total amount of urinary output on the I & O chart under Urine-amount for 8-hour total.

LEARNING ACTIVITIES - continued

SITUATION: A fresh 2,000 cc bottle of irrigation solution was added to the Foley at 0900, after the first 2,000 cc bottle ran out of solution. The collecting bottle was emptied and contained 2,650 cc's of urinary drainage. At 1100, another fresh 2,000 cc bottle of solution was added and the collecting bottle contained 2,400 cc's. At the end of the shift, the total amount of output was added up to equal 5,050 cc's and the total amount of irrigation solution was added up to equal 4,000 cc's. The 4,000 cc's was subtracted from the 5,050 cc's to equal 1,050 cc's of urinary output.

	OUTPUT						
	Urine					Irrigation	
	Source	Amt.	Source	Source	Source	Added	Out
		cc					
		650				2000	
							2,650 cc
						2000	
		400					2,400 cc
8 Hr. Total		1050				4000	5,050 cc
		Total Urinary Output				Total Irrigation Solution	Total Output

Subtract

5050 cc (Total output)
-4000 cc (Total added)
1050 cc (Total urinary output)

Exercise 1.

Directions: Answer these questions by filling in the blanks or by circling TRUE or FALSE. Answers can be found on page 7 of this module.

1. The doctor will never order continuous bladder irrigations for a patient with a bladder infection because the treatment would further irritate the bladder.
   TRUE FALSE

2. The solution most frequently used for continuous bladder irrigations is ________ ______________________________ solution.

3. Why is it necessary to check the rate of flow from the irrigation bottle and compare that rate with the rate of flow of urinary drainage?

   ____

4. You should always check the color of drainage in the collecting bottle and report changes in color to the nurse in charge. TRUE FALSE

LEARNING ACTIVITIES - continued

5. Perineal care should be given to your patient with a continuous Foley irrigation at least ________ times a day.

6. Perineal care to the patient with a catheter is also known as ________________ care.

7. State three complaints of a patient receiving continous bladder irrigations that you would report immediately to the nurse in charge.

   a. ______________________________________

   b. ______________________________________

   c. ______________________________________

8. It is not necessary to use aseptic technique when changing the bottle of the irrigation solution because the bladder contains its own normal bacteria.

   TRUE FALSE

Exercise 2.

Directions: Read the following situation and fill in the I & O Record Sheet provided below. Discuss the completed form with your instuctor. Then figure the urinary output for an eight-hour shift and mark it in the proper column on the I & O Record Sheet. Check your answers by referring to page 7 of this module.

SITUATION: You hang a fresh 2,000 cc bottle of irrigation solution to the Foley at 0900. You emptied the collecting bottle and it contained 2,400 cc. Again, at 1:30 p.m., you hang another 2,000 cc bottle of irrigation solution and empty the collecting bottle for 2,560 cc.

	OUTPUT						
	Urine					Irrigation	
	Source	Amt.	Source	Source	Source	Added	Out
8 Hr. Total							

LEARNING ACTIVITIES - concluded

ACTIVITY #2. Demonstrate What You Have Learned

Directions: Demonstrate the following procedures.

1. Catheterize the mannequin, "Mrs. Chase."
2. Connect the catheter to a continuous Foley irrigation.
3. Fix any excess drainage tubing.
4. Position the collecting bottle.
5. Tape the catheter to "Mrs. Chase's" leg.
6. Demonstrate the procedure for hanging a bladder irrigation bottle.

ANSWERS

ACTIVITY #1

Exercise 1

1. FALSE
2. normal saline
3. to make sure that the catheter is not plugged with a blood clot or with sediment
4. TRUE
5. 3
6. meatal care
7. a. the bladder feels full
   b. "bladder spasms"
   c. leakage of urinary drainage around the catheter
8. FALSE

Exercise 2

	OUTPUT						
	Urine					Irrigation	
	Source	Amt.	Source	Source	Source	Added	Out
						2000	
							2400 cc
						2000	
							2,560 cc
8 Hr. Total		960				4000	4,960 cc

NURSING ASSISTANT SKILLS

Module G3 - Urine Straining

RATIONALE

Patients are often admitted to the hospital with a diagnosis of "stones" in the kidney or bladder. You will be responsible for straining the urine of such a patient to catch these stones as they are passed out of the body.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate and answer verbal questions on the procedure for straining urine.
2. Identify characteristics of a kidney/bladder stone.

LEARNING ACTIVITIES

Directions: Module G3 is interesting and short. Read the information and answer the questions. You will be asked to demonstrate the procedure for straining urine as you care for patients in the health care facility. Your instructor will help you if you have any questions.

ACTIVITY #1. Renal Calculi

Directions: Read the following information.

The formation of renal calculi is a common kidney condition. Your patient will call these calculi "stones" which is exactly what they are. Stones may form in the kidney and be passed into the bladder or they may form in the bladder. Kidney stones can cause an obstruction or blockage if they become lodged in the ureters. When this happens, your patient will complain of a sudden, severe pain in the lower side of the back. All the urine that is voided must be strained to check for calculi as they are passed through the bladder and out of the body. The calculi will be either a gray or beige color and will look like fine, gravel particles or sand.

ACTIVITY #2. Procedure for Straining Urine

Directions: Read the procedure on the following page. You will be asked to demonstrate STRAINING URINE as you care for patients in the clinical area.

LEARNING ACTIVITIES - concluded

PROCEDURE: STRAINING URINE	DEMONSTRATION/COMMENTS
1. Explain to the patient that you will be straining all of the urine to check for stones. Ask that all specimens be saved. If your patient needs the urine strained, what might the diagnosis be?	1. ____________________
2. Collect the urine in the bedpan or urinal and take the specimen to the patient's bathroom.	2. ____________________
3. Position the strainer over the measuring container. Pour the urine from the bedpan or urinal through the strainer into the measuring container.	3. ____________________
4. Check the strainer for any sandlike or gravel particles. What are these sandlike or gravel particles called?	4. ____________________
5. Discard the urine in the toilet.	5. ____________________
6. If you have collected any gravel, place it in a container and immediately report it to the nurse in charge. If you have not collected any gravel, rinse the strainer.	6. ____________________

Directions: Answer the following questions by filling in the blanks. Answers can be found in the preceding information.

1. Another word meaning "kidney" is ____________________.
2. Renal calculi are the same thing as ____________________ in the kidney.
3. Calculi are dangerous because they may become lodged in the ____________________ as they pass down from the kidney to the bladder.
4. When calculi are lodged in the ureters, they cause an ____________________.
5. If your patinet has renal calculi, all of the urine will be ____________________ to catch the stones as they are passed out of the body.
6. Describe what a kidney or bladder stone may look like.

   ____

7. List the equipment necessary to strain urine.

   a. ____________________ b. ____________________

NURSING ASSISTANT SKILLS

Module G4 - Specific Gravity of Urine Measurement

RATIONALE

The nurse in charge may ask you to test your patient's urine for the specific gravity. In this part of Module G, you will learn the procedure for measuring the specific gravity of urine and why the test is done.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the normal specific gravity of urine and the reasons for any changes in the reading.
2. Name the instrument used to measure specific gravity of urine.
3. Demonstrate the procedure for measuring the specific gravity of urine.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this part of Module G is included. Read the information and answer all of the questions. You will be asked to demonstrate measuring the specific gravity of urine. If you need any help, get it!!

ACTIVITY #1. Specific Gravity of Urine

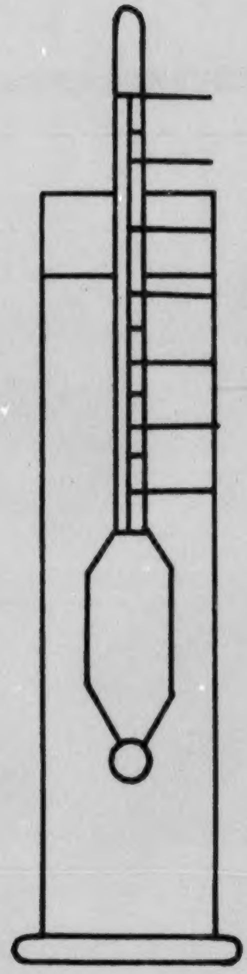
Directions: Read this material.

The specific gravity of urine is a test done to determine the ability of the kidneys to concentrate or dilute urine according to the needs of the body. If the body is dehydrated, the kidneys conserve water which decreases the amount of water in urine. The specific gravity of urine will then go up. If the fluid intake is good, the kidneys will pass out any of the excess water as part of the urine. The specific gravity will then go down. At times, the kidneys may not function properly to concentrate urine. The urine will be very diluted with water taken from the blood and the body will become dehydrated. At other times, the heart may be damaged and water in the bloodstream that would usually be passed out through the kidneys may pass into the tissues under the skin as edema. Kidney damage or disease may prevent the kidneys from properly filtering water out of the bloodstream. In these cases, there will not be much water in the urine at all. The urine will be very concentrated.

LEARNING ACTIVITIES - continued

Specific gravity is measured by a urinometer. A urinometer is an instrument which contains a mercury bulb attached to a glass stem with a scale indicating a range of concentration from 1.000 to 1.060.

The normal specific gravity of urine is 1.010 to 1.030. The normal specific gravity of water is 1.000 so, if the specific gravity of urine is close to 1.000, it means that the urine is diluted with water. When the specific gravity of urine moves further away from 1.000, it means that the urine contains less water and is more concentrated.



URINOMETER IN CYLINDER

Exercise.

Directions: Answer the following questions by filling in the blanks or by circling TRUE or FALSE. Answers to this exercise can be found in the preceding information.

1. Specific gravity measures the ability of the kidneys to ________________ and ______________ urine.
2. Specific gravity is measured by an instrument called a ____________ ___________.
3. The normal specific gravity of urine is from ____________ to ________________.
4. If the specific gravity of urine goes down, the urine is more concentrated.
   TRUE FALSE
5. If the urine is light yellow in color and looks almost like water, the specific gravity is probably (high, low).

LEARNING ACTIVITIES - continued

ACTIVITY #2. Procedure for Measuring the Specific Gravity of Urine

Directions: Ask your instructor to demonstrate how to use the urinometer. If you have any questions, ask for answers before you go any further. Then read the procedure below. When you demonstrate the procedure, your instructor will check off the steps as you accomplish them.

PROCEDURE: MEASURING THE SPECIFIC GRAVITY OF URINE	DEMONSTRATION/COMMENTS
1. Collect equipment: measuring container and a urinometer.	1. ______________________
2. Explain that you will be testing the urine and ask the patient to save the urine the next time there is a need to void.	2. ______________________
3. Pour the urine into the urinometer cylinder to fill the jar to about one inch from the top. You will need at least 30 to 45 cc's of urine.	3. ______________________
4. Hold the urinometer from the top and slowly insert into the urine. Avoid wetting the glass stem above the urine line.	4. ______________________
5. Gently spin the urinometer float in the urine.	5. ______________________
6. When the urinometer comes to rest, read the urinometer at the urine line. Be sure to keep the urinometer away from the sides of the cylinder while reading. Each line on the stem is equal to 0.001.	6. ______________________
7. Rinse the urinometer and cylinder in water. If the instrument is to be used for this patient again, fill the cylinder with water and insert the urinometer in the cylinder until the next using.	7. ______________________

LEARNING ACTIVITIES - concluded

Exercise.

Directions: Demonstrate what you have learned by measuring the specific gravity of urine.

1. Collect a sample of your own urine.
2. Take the checklist in this module to your instructor and demonstrate the procedure for measuring the specific gravity of urine.
3. Now dilute your urine with water.
4. Measure the specific gravity again and ask your instructor to check your reading. What happened to the specific gravity? Why?
5. Dissolve sugar in your urine and measure the specific gravity again. What happened this time? Why?

NURSING ASSISTANT SKILLS

Module G5 - Urine Test for Blood

RATIONALE

If the bladder is severely irritated or if the kidneys are damaged, you may notice that the patient's urine may be bloody or pink-tinged. Urine that looks bloody may be tested for blood.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify symptoms of cystitis.
2. Demonstrate the procedure for testing urine for blood.

LEARNING ACTIVITIES

Directions: This part of Module G is another short and easy section. All of the information is included. Be sure to answer all of the questions.

ACTIVITY #1. Cystitis

Directions: Read the following information.

Cystitis is the inflammation of the urinary bladder. When the bladder is inflamed, the patient will feel like voiding more frequently (like maybe every hour) and will void in small amounts of 50-100 cc's of urine at a time. The patient may complain of a burning pain when urinating. When you examine the patient's urine, you may notice that it has a very foul odor, and it may be cloudy in color instead of the clear yellow color. Sometimes, the bladder may become so inflamed and irritated that it may bleed. If the urine has a pink color, it may have some blood in it and you will need to test the urine for blood with a hemastix. Read the following procedure for testing urine for blood.

Procedure for Testing Urine for Blood

PROCEDURE: TESTING URINE FOR BLOOD	DEMONSTRATION/COMMENTS
1. Collect the necessary equipment: bottle labeled "Hemastix Reagent Strips", color chart on the bottle, measuring container.	1. ____________________
2. Obtain a sample of urine and pour urine from the bedpan or urinal into the clean measuring container.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: TESTING URINE FOR BLOOD	DEMONSTRATION/COMMENTS
3. Remove the hemastix strip from the bottle labeled "Hemastix Reagent Strips". Be careful not to touch the test area of the strip with your fingers. You may falsify the results of the test. Dip the testing end of the hemastix strip into the urine and remove immediately.	3. ______________________
4. Tap the edge of the strip against the measuring container to remove excess urine and wait 30 seconds.	4. ______________________
5. Compare the color of the testing end of the hemastix strip with the color chart on the bottle. If the urine has blood in it, the test end will turn from light blue to dark blue. If the urine does not contain blood, the end will remain a neutral cream color.	5. ______________________
6. Discard the urine in the toilet.	6. ______________________
7. Report the results of the test to the nurse in charge as "negative for blood" if the urine does not contain blood, or, "positive for a small, moderate, or large amount of blood" if the urine does contain blood.	7. ______________________

Exercise.

Directions: Answer the following questions on Testing Urine for Blood by filling in the blanks. Answers can be found on page 4 of this module.

1. Cystitis is the inflammation of the ______________________________.

2. We normally feel the urge to empty the bladder when ________ cc's of urine have accumulated in the bladder.

3. A patient with cystitis will feel like voiding (more often, less often) and will void in (larger amounts, smaller amounts) than normally.

4. Urine normally has a ____________ color and if allowed to stand, it has a smell of ________________________.

5. When a patient has cystitis, the urine may have a ________________ color and a very foul odor.

LEARNING ACTIVITIES - concluded

6. Urine that is pink-tinged may be bloody and needs to be tested for blood with a __________________________.

7. After dipping the testing strip into the urine, you must wait _______ seconds before comparing the strip with the color chart.

8. What color will the strip turn if the urine is "positive" for a small amount of blood? ______________________________________

9. If the strip is a neutral cream color, how would you report the results to the nurse in charge? ____.

ACTIVITY #2. Demonstration of Testing Urine for Blood

Directions: Practice the procedure for testing urine for blood. Then take this module to your instructor and demonstrate the procedure.

ANSWERS

ACTIVITY #1

1. bladder
2. 250 cc's
3. more often, smaller amounts
4. clear, yellow; ammonia
5. cloudy
6. hemastix
7. 30
8. light blue
9. "negative for blood"

NURSING ASSISTANT SKILLS

Module G6 - Collection of Urine Specimens

RATIONALE

In renal or kidney diseases, examination of the urine is an important aid to diagnosis. As a nursing assistant, you will often be asked to save a specimen of urine from your patient.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate:
    a. Collecting a urine specimen for routine analysis.
    b. Collecting a clean-catch or mid-stream urine specimen.
    c. Collecting a patient's urine for 24-hour analysis.
    d. Proper labeling of each specimen and sending the specimen to the laboratory.
2. Identify the characteristics of a normal sample of urine and a contaminated sample of urine.

LEARNING ACTIVITIES

Directions: Read the information in this section and answer the questions. You will be asked to demonstrate the procedure for collecting urine specimens as you care for patients. Remember, you can always ask your instructor for help.

ACTIVITY #1. Urine

Directions: Read the following information.

Urine is the fluid which is secreted by the kidneys and is excreted by the bladder. It consists of about 96% water; the remaining 4% is made up of salts and urea. Urea is a waste product from the metabolism of protein foods and is poisonous to the body if allowed to accumulate in the blood.

When freshly voided, urine is a light yellow color. If permitted to stand, a specimen may become cloudy and it will develop an ammonia-like odor. Urine is sterile which means it is free of bacteria. The specimen should be clear. You should be able to see through it. Cloudy particles or sediment in fresh urine may mean it is contaminated with bacteria. Urine is normally acid. The high acidity level helps to suppress the growth of bacteria. A normal sample of urine should not contain any dissolved protein called albumin or glucose and should not contain any red or white blood cells.

LEARNING ACTIVITIES - continued

Exercise.

Directions: Answer the following questions. Answers to this short exercise can be found by rereading the preceding information. If you have any problems, see your instructor.

1. Describe a normal sample of urine.

   ____

   ____

2. How much of the urine is water?

   a. 50%
   b. 67%
   c. 96%
   d. 80%

3. ____________________ is a waste product from the metabolism of protein and is passed out of the body as a part of the urine.

4. Urine is (excreted, secreted) by the kidneys and is (excreted, secreted) by the bladder.

5. If urine is free of bacteria, it is ______________________________.

6. Dissolved protein called __________________________ in urine is an indication of kidney damage.

ACTIVITY #2. Collecting Urine Specimens

Procedure for Collecting a Routine Urine Specimen

Directions: Read the following procedures. When you demonstrate each procedure, your instructor will check off the steps as you accomplish them.

PROCEDURE: COLLECTING A ROUTINE URINE SPECIMEN	DEMONSTRATION/COMMENTS
1. Collect the equipment: a specimen container, a clean measuring container or clean urinal, or bedpan.	1. ________________________

LEARNING ACTIVITIES - continued

PROCEDURE: COLLECTING A ROUTINE URINE SPECIMEN **DEMONSTRATION/COMMENTS**

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2. Explain to your patient that the doctor has ordered a urine test and a sample of urine is needed. If able to get up to the bathroom, ask the patient to void in the clean measuring container, to leave the specimen in the bathroom, and to call you when finished. If your patient is not able to go to the bathroom alone, offer a clean urinal or bedpan for urination.

2. ____________________

3. Take the bedpan or urinal to the patient's bathroom and pour 90-120 cc of urine into the specimen container. The specimen must be free of stool and menstrual blood. If the patient is menstruating, you must add that information to the label.

3. ____________________

4. Wash your hands. Do not contaminate the outside of the specimen container.

4. ____________________

5. Cover the container with the lid — securely.

5. ____________________

6. Attach the label and request slip to the specimen container. Be sure the label and the request slip include the following information:

   Patient's full name
   Patient's room number
   Date of collection
   Time of collection
   Physician's name
   Patient's hospital number
   Examination to be performed

6. ____________________

7. Clean and replace the urinal or the bedpan.

7. ____________________

8. Tell your instructor that you need to send the specimen to the laboratory. The procedure for sending the specimen to the lab changes with every health care facility. You will need to find out what the procedure is at the place you work.

8. ____________________

LEARNING ACTIVITIES - continued

Collecting a Clean-Catch Urine Specimen

Directions: Read the following information.

The physician may order a clean-catch urine specimen from a patient with a bladder or kidney infection. (A clean-catch urine specimen is the same thing as a midstream urine specimen.) The specimen is tested for culture and sensitivity.

The doctor is asking that the patient's urine be cultured to determine what bacteria is causing the infection. Then the antibiotic that the bacteria is the most sensitive to can be found. The patient may then be treated with that antibiotic.

Remember, the bladder is a sterile body cavity and urine does not normally contain any bacteria. A clean-catch specimen cannot be called a sterile urine specimen, it is only clean. It may be contaminated as it is voided, but it is as clean a specimen as can be obtained without catheterizing the patient.

Procedure for Collecting a Clean-Catch Urine Specimen

PROCEDURE: COLLECTING A CLEAN-CATCH URINE SPECIMEN	DEMONSTRATION/COMMENTS
1. Collect the equipment: a clean-catch kit that will contain a sterile specimen container and a lid and three packets of antiseptic wipes.	1. ____________
2. Explain to your patient that the doctor has ordered a urine test and a sample of urine is needed.	2. ____________
3. Wash your hands thoroughly.	3. ____________
4. Place the patient (both men and women) on the bedpan and clean the urinary meatus with the packets of antiseptic solution. (See Module A - GIVING PERINEAL CARE). Wash the area three times, using a new antiseptic towelette each time. Remember: USE DOWNWARD STROKES — DO NOT WASH UPWARD!!!	4. ____________

LEARNING ACTIVITIES - continued

PROCEDURE: COLLECTING A CLEAN-CATCH URINE SPECIMEN		DEMONSTRATION/COMMENTS
5.	Instruct the patient to begin urinating into the bedpan. Very soon after the patient has started to urinate, ask him to stop and position the sterile specimen container to take a urine sample. DO NOT LET THE CONTAINER TOUCH THE PATIENT. If the container touches the patient, it is contaminated and you must get a new sterile container. If your patient is unable to stop urinating in the middle of voiding, position the container to collect a specimen after he has started to urinate without asking him to stop the flow.	5. ____________
6.	Wash your hands. Cover the container with a sterile lid. Be sure you do not touch the inside of the lid and that you do not place the lid on a table or shelf with the inside down.	6. ____________
7.	If your patient is able to follow instructions and can get up to the bathroom, he may be able to collect his own specimen. You will be responsible for explaining the procedure to the patient.	7. ____________
8.	Have your patient repeat what you have said. Make sure he understands the procedure.	8. ____________
9.	Attach the label and the request slip to the container.	9. ____________
10.	Send the specimen to the laboratory.	10. ____________

Exercise.

Directions: Answer the following questions. Discuss your answers with your instructor.

1. Why should you avoid touching the inside of the lid?

____

LEARNING ACTIVITIES - continued

2. Write down how you would explain the procedure for collecting a clean-catch urine specimen to your patient.

____

____

3. List the seven items of information a properly labeled container includes.

a. ______________________

b. ______________________

c. ______________________

d. ______________________

e. ______________________

f. ______________________

g. ______________________

4. What is the procedure for sending the specimen to the laboratory in the facility where you are working? ______________________

____

Procedure for Collecting Urine for 24-Hour Urinalysis

PROCEDURE: COLLECTING URINE FOR 24-HOUR URINALYSIS	DEMONSTRATION/COMMENTS
1. Collect the equipment: a gallon specimen bottle, measuring container, pan and ice.	1. ______________
2. Explain to your patient that the doctor has ordered a urine test and all of the urine for 24 hours will be collected and saved.	2. ______________

LEARNING ACTIVITIES - concluded

PROCEDURE: COLLECTING URINE FOR 24-HOUR URINALYSIS	DEMONSTRATION/COMMENTS
3. Label the gallon bottle with: Patient's name "24-hour specimen" Time and date the collection was started Time and date the collection was finished REMEMBER: It will be finished at the same time as when started; but, the date will be one day later.	3. ______________
4. At the time that the test is to be started (usually between 0700 to 0800), give the patient a clean bedpan or urinal and ask her to void. Throw out this first specimen.	4. ______________
5. After this first time, each time the patient voids, pour urine from the bedpan or urinal into the measuring container and then pour the urine into the large specimen bottle. SAVE ALL THE URINE FOR THE NEXT 24 HOURS.	5. ______________
6. Keep the large gallon bottle in a pan of ice in the patient's bathroom and replace the ice as it melts. The ice helps to preserve the urine and keeps the odor down.	6. ______________
7. The next day, at the same time that the test was started the day before, ask the patient to urinate and save this last specimen in the gallon bottle.	7. ______________
8. Attach the label and the request slip to the gallon container.	8. ______________
9. Send the specimen to the laboratory.	9. ______________

NURSING ASSISTANT SKILLS

Module G7 - Urethral Catheterization and Closed Drainage

RATIONALE

You may take voiding for granted. Some of your patients will be unable to void. You will need to understand the sterile technique of urethral catheterization to give safe nursing care to your patient.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the reasons catheters are used.
2. Demonstrate male and female urethral catheterization.
3. Demonstrate collecting a sterile specimen.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this module is included here and in the Trainex filmstrip, Male and Female Catheterization. Read the information and study the diagrams. You will be asked to demonstrate the procedure for a male and a female catheterization and for the collection of a specimen from a closed drainage system.

ACTIVITY #1. Inserting Catheters

Directions: Read the following information carefully. If you have any questions, ask your instructor to help you answer them.

Reasons for Using Catheters

1. To obtain the cleanest possible specimen for testing purposes. A straight catheter is used for this purpose and is not left in the bladder.
2. To empty the bladder of urine when a condition of retention is suspected or to determine amount of residual urine left in the bladder after patient voids. CAUTION: If 1,000 cc of urine has drained, clamp catheter for 30 minutes, then open clamp and allow remainder of urine to drain. (This allows the body to accommodate to fluid loss, preventing shock and bladder spasms.) A straight catheter is also used for this unless the doctor orders a Foley to be left in the bladder.
3. To prevent the patient's voiding voluntarily or involuntarily when the patient's condition necessitates keeping the genitalia and surrounding area clean and dry. A Foley catheter is used for this purpose and is left in the bladder until the doctor leaves an order to have it removed.

LEARNING ACTIVITIES - continued

Points to Remember When Using Catheters

1. A physician's order is required to catheterize a patient.
2. A closed urinary system is never opened unless absolutely necessary.
3. Foley care will be given every eight hours using a designated scrub solution and/or ointment.

Procedure Guidelines for Inserting Catheters

1. Give a thorough explanation of the procedure to the patient.
2. Keep the patient warm for comfort and as a means of promoting relaxation of urethral musculature.
3. Have all equipment within reach.
4. A good light must be directed on meatus.
5. Always wash your hands before and after procedure.

ACTIVITY #2. Catheterization

Procedure for Female Catheterization

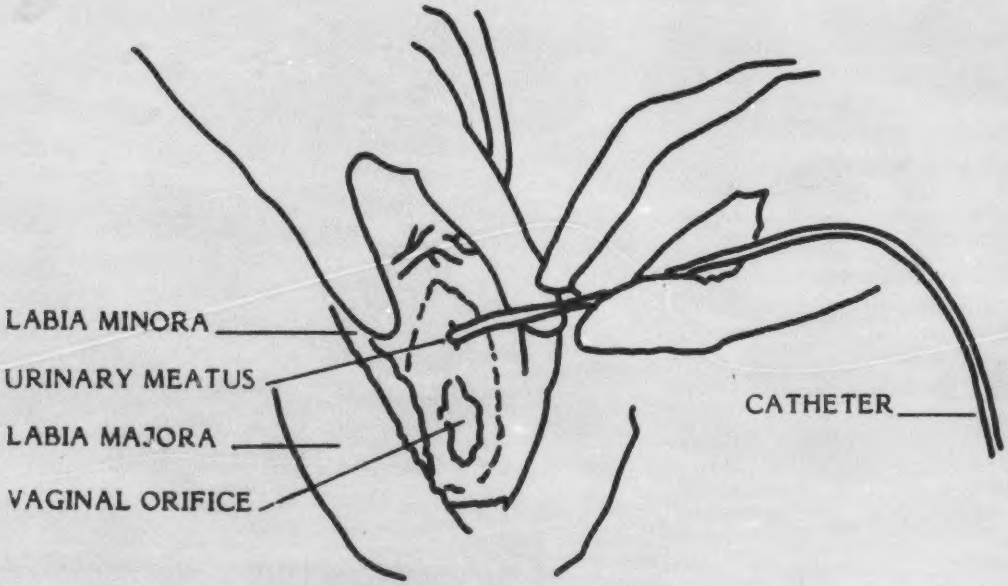
Directions: Read the procedure below. When you have learned the appropriate procedure, you will demonstrate it to your instructor. When you demonstrate the procedure for female catheterization, your instructor will check off the steps as you accomplish them.

PROCEDURE: FEMALE CATHETERIZATION *	DEMONSTRATION/COMMENTS
1. Collect your equipment.	1. ____________________
2. Position and drape patient with bath blanket.	2. ____________________
3. Check with patient for skin allergies to iodine preparation.	3. ____________________
4. Open the sterile catheterization set and position set between patients legs within easy reach.	4. ____________________
5. Put on sterile gloves.	5. ____________________

*Not all nursing assistants insert catheters. Check with your facility concerning their policy.

LEARNING ACTIVITIES - continued

PROCEDURE: FEMALE CATHETERIZATION	DEMONSTRATION/COMMENTS
6. Lift disposable drape and make a cuff with drape, covering the sterile gloves.	6. ____________
7. Have the patient lift buttocks and quickly slip drape in place being careful not to contaminate the gloves.	7. ____________
8. Prepare all sterile items for use.	8. ____________
9. Using sterile forceps, cleanse the genitalia with Betadine soaked sponges (or Phisohex, if patient is allergic to iodine) using a gentle but firm downward motion. Use a different sponge for each stroke. (side, side, middle) The hand used to separate the labia is now considered contaminated. Maintain this position.	9. ____________
10. Using the sterile glove hand, dip the tip of the catheter into lubricant and insert the catheter into the urethral meatus without allowing anything to touch that part of the catheter that comes in contact with the urethra. (See diagram below)	10. ____________

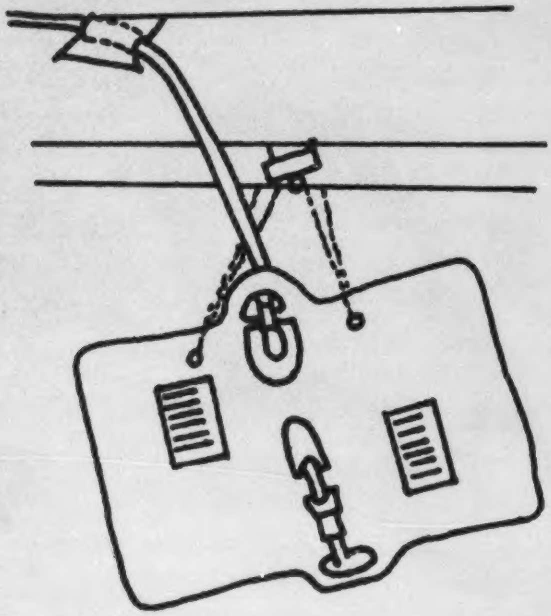


LEARNING ACTIVITIES - continued

PROCEDURE: FEMALE CATHETERIZATION	DEMONSTRATION/COMMENTS
11. Instruct the patient to take a breath and on exhalation introduce the catheter in an upward and backward direction about 4 cm or until urine begins to flow. Then insert catheter one inch further.	11. ________________
12. Collect the specimen after urine has begun to flow freely. Protect the open end of the catheter from contamination.	12. ________________
13. After urine ceases to flow freely, withdraw the catheter slightly to see whether any more urine will flow with the tip of the catheter nearer the urethral outlet.	13. ________________
14. Withdraw the catheter slowly and gently.	14. ________________
NOTE: If it's a Foley catheter that is left in place, inflate the balloon with appropriate amount of sterile water. Then:	
15. Connect catheter to drainage set up. The catheter should then be pushed inward about 2 cm. This is the point at which the patient will be most comfortable with the catheter indwelling, since the inflated balloon does not infringe on the bladder outlet and create the desire to urinate.	15. ________________
16. The drainage tube should be anchored to prevent tension or pulling of the catheter. Externally rotate the leg and secure catheter to inner thigh using paper tape.	16. ________________

LEARNING ACTIVITIES - continued

PROCEDURE: FEMALE CATHETERIZATION	DEMONSTRATION/COMMENTS
17. Catheter should now be in proper place; tubing over top of leg, excess tubing fastened to top of bed, drainage bag hanging on bed frame below bladder. (See diagram below.)	17. ______________



Procedure for Male Catheterization

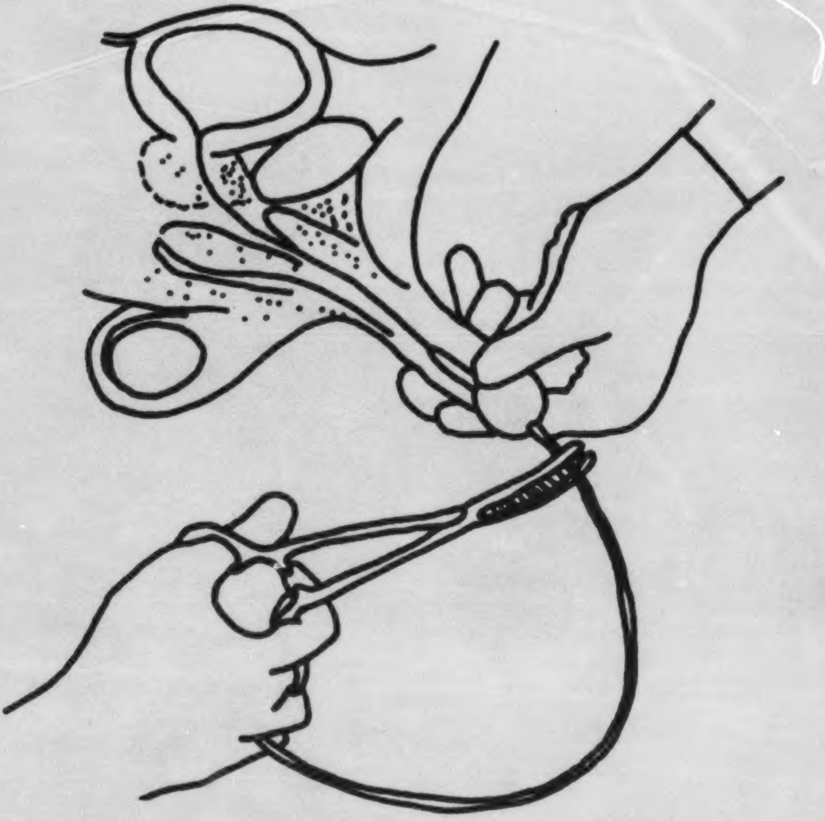
Directions: Read the following procedure. When you have learned the appropriate procedure, you will demonstrate it to your instructor. When you demonstrate the procedure for male catheterization, your instructor will check off the steps as you accomplish them.

PROCEDURE: MALE CATHETERIZATION*	DEMONSTRATION/COMMENTS
1. Place the patient in supine position.	1. ______________
2. Wash your hands.	2. ______________
3. Open the sterile catheter set.	3. ______________
4. Put on sterile gloves.	4. ______________

*Not all nursing assistants insert catheters. Check with your facility concerning their policy.

LEARNING ACTIVITIES - continued

PROCEDURE: MALE CATHETERIZATION	DEMONSTRATION/COMMENTS
5. Place disposable drape across upper thighs close to pubic area.	5. ______________________
6. Prepare all sterile items for use.	6. ______________________
7. Place a sterile towel over the penis and with gloved hand grasp the penis and hold penis perpendicular to the body. Using the forceps, thoroughly cleanse the glans penis with Betadine or Phisohex soaked sponges.	7. ______________________
8. Using the sterile gloved hand, dip the tip of the catheter into lubricant. To facilitate relaxation and easy insertion, have patient take a deep breath and on exhalation introduce catheter into urethral meatus without allowing anything to touch that part of the catheter that comes in contact with the urethra. (See diagram below.)	8. ______________________



LEARNING ACTIVITIES - continued

PROCEDURE: MALE CATHETERIZATION	DEMONSTRATION/COMMENTS
9. Initially the penis is held perpendicular to the body. As the catheter meets with resistance when it approaches the posterior urethra, the penis should be positioned parallel to the thighs. When the urine flow is obtained, the Foley catheter should be inserted all the way to the bulb inflation inlet and the balloon inflated. Connect to drainage system and secure the catheter on thigh.	9. ______________________
10. Observations to chart or report: Time of procedure, any difficulties with procedure. Size, type, balloon size of catheter, amount of urine obtained initially, color, odor, consistency of urine (if tube is kinked).	10. ______________________

ACTIVITY #3. Collecting a Urine Specimen from a Closed Drainage System

Directions: Read the following and study the diagrams carefully.

Never open the urinary drainage system unless absolutely necessary. Use the sterile irrigating system with sterile water or normal saline.

Procedure for Collecting a Urine Specimen Without Opening Urinary Drainage System

1. Clamp the drainage tube.
2. Wait until a column of urine collects.
3. Cleanse the outlet portion.
4. Insert a sterile 22 g needle 5-10cc syringe through the distal end of the catheter (A) with the needle in a slanted position to assure self-sealing of the rubber. (Silaslic, silicone, and plastic catheters do not self-seal.) To avoid accidental puncturing of the lumen leading to the balloon, slant the needle toward the drainage tubing.

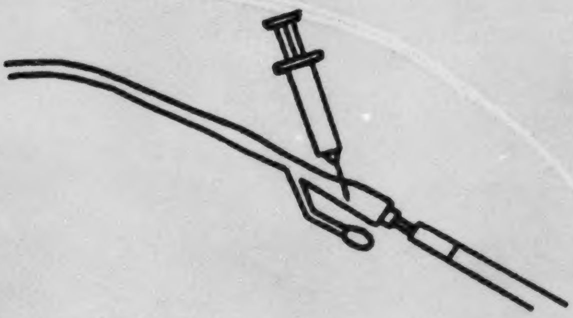


FIGURE A

LEARNING ACTIVITIES - concluded

5. If no urine is available at that point, carefully lift the tubing to return a small amount of urine. Caution: Do not force any urine back into the bladder. Still no urine? Kink the tubing 3 inches from the catheter and hold in place with a rubber band until urine is visible.

6. Some urinary drainage bags have a sampling port on the tubing specifically for obtaining specimens (B). No matter which set-up you use, however, aseptic technique is essential. Don't forget to swab the puncture site with antiseptic before you inject the needle.

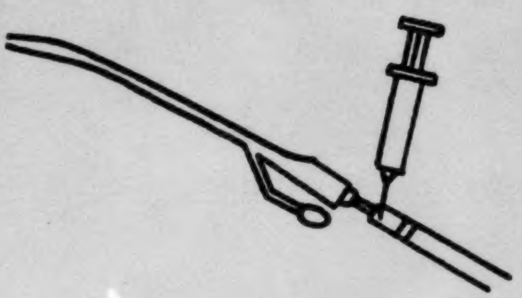


FIGURE B

7. Cap and label the urine filled syringe or transfer the specimen to a sterile container. If you cannot get the specimen to the laboratory within a half hour, store it in the refrigerator until you can.

NURSING ASSISTANT SKILLS

Module H - Endocrine System: Test Urine for Sugar and Acetone

RATIONALE

As you care for the diabetic patient in the health care facility, you may be asked to test the urine for sugar and acetone. This module will tell you how.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the definition of fractional.
2. Identify the reasons for testing urine of a diabetic.
3. Demonstrate and record:
    a. Clinitest and acetest of urine
    b. Bili-Labstik of urine
    c. Keto-Diastix of urine
    d. Tes-tape

LEARNING ACTIVITIES

Directions: This is a short module. Read the material and answer all of the questions. You will be asked to test a sample of your urine, so wait until after you have finished reading the module before you take a break.

ACTIVITY #1. Clinitest

Directions: Read this information.

Clinitest is a test for urinary glucose or sugar. Other tests that mark the presence of glucose in the urine are Clinistix and Tes-Tape. The Tes-Tape is frequently used if the diabetic patient is on drugs such as antibiotics that are excreted in the urine. The presence of antibiotics in urine may give a false reading to the clinitest.

Since diabetic patients are unable to normally metabolize the sugar they eat, some of the glucose that accumulates in the bloodstream may be excreted as part of the urine. At certain times during the day, the diabetic may have large amounts of glucose in the urine and at other times, there may not be any. The diabetic's urine should be tested one-half hour before each meal and at bedtime. The physician may order that the urine tested be "fractional". This means that only very fresh urine should be tested and not the urine that has accumulated in the patient's bladder. To obtain a fractional urine, you must have the patient void one-half hour before the

LEARNING ACTIVITIES - continued

time you wish to test the urine (or void one hour before mealtime). This urine is discarded. Then, at the time you want to clinitest the urine, you ask the patient to void again. Remember, a few drops of urine is all that is necessary to test. This second specimen is the one you test.

Procedure for Clinitesting Urine

PROCEDURE: CLINITESTING URINE	DEMONSTRATION/COMMENTS
1. Collect equipment: Clinitest reagent tablets, dropper, test tube, and color chart that all come in the test kit and which may be obtained from your pharmacy.	1. ______________
2. Collect urine in a clean bedpan, urinal, or measuring cup.	2. ______________
3. With the dropper in upright position, measure five drops of urine into the test tube. Rinse the dropper and add ten drops of water to the tube.	3. ______________
4. Pour the clinitest tablet from the bottle into the cap of the bottle. Do not touch the tablet. Drop the tablet into the test tube.	4. ______________
5. As the tablet dissolves, it give off heat and bubbles. After the boiling has stopped, wait 15 seconds and then shake the test tube gently.	5. ______________
6. The liquid has changed color. Compare the color to the color chart. If the color is blue, no glucose is present and the test results are recorded as "negative". If the color ranges from green to orange, the test results will be recorded as "trace, 1+, 2+, 3+" for sugar.* Orange-red color indicates "4+" sugar.	6. ______________
7. The results of every clinitest should always be reported immediately to the nurse in charge.	7. ______________

---

*The procedure for recording such information will differ from unit to unit and from facility to facility.

LEARNING ACTIVITIES - continued

Exercise.

Directions: Complete the following exercise. Check your answers with the information on the preceding pages.

1. Clinitest is a test for urinary ____________________.
2. Two other tests that also test the urine besides the clinitest are ______________ and ____________________.
3. When is the Tes-Tape used to test urine instead of clinitest tablets?

   ____.
4. The diabetic's urine should be tested (1 hour A.C., ½ hour A.C., 1 hour P.C., or ½ hour P.C.) and at bedtime.
5. How would you obtain a "fractional" urine? ________________________________

   ____.
6. How much urine is measured into the test tube? ____________________________
7. How much water is measured into the test tube? ____________________________
8. How long do you wait before shaking the test tube? __________________________
9. How would you record test results that are blue in color? __________________
10. How would you record test results that are orange-red in color? ______________

    ____.
11. The results of a clinitest should be reported to the nurse in charge only if the results are 1+ to 4+. TRUE FALSE

ACTIVITY #2. Acetest

Directions: Read this material.

A diabetic patient must also have the urine tested for acetone or ketone at the same time that the urine is clinitested. Acetone appears in the urine when fat is used for energy by the body in place of glucose. The technique used for testing acetone is the Acetest.

LEARNING ACTIVITIES - continued

Procedure for Acetesting Urine

PROCEDURE: ACETESTING URINE	DEMONSTRATION/COMMENTS
1. Collect equipment: Acetest reagent tablets, dropper, clean paper towel, color chart.	1. ______________________
2. Collect urine in a clean receptacle.	2. ______________________
3. Pour one tablet from the bottle into the cap of the bottle and then place the tablet on a clean paper towel. Do not touch the tablet.	3. ______________________
4. Drop one drop of urine on the tablet.	4. ______________________
5. Wait 30 seconds and compare the color of the tablet to the color chart. The results are recorded as "negative" if the tablet does not change color. "Positive" results are recorded as "small, moderate, or large" depending on the shade of purple the tablet changes to.*	5. ______________________
6. The results of every acetest should always be reported to the nurse in charge immediately.	6. ______________________

*Recording procedure differs from facility to facility.

Exercise 1.

Directions: Answer these questions. Answers can be found in the preceding information.

1. Acetone appears in urine when ____________ is used for energy instead of glucose.
2. Acetest tests the presence of acetone or ______________ in the urine.
3. How many drops of urine are placed on the tablet? ________________
4. How long do you wait before comparing the color of the tablet to the color chart? ________________
5. Acetest tests whether or not the urine is acid. TRUE FALSE
6. How are the results recorded if the tablet does not change color? ___________

LEARNING ACTIVITIES - continued

7. If the tablet turns ___________, the test results are positive and you will record the results as __________, ____________, or ______________.

8. When do you report the acetest results to the nurse in charge? _____________

Exercise 2.

Directions: Now, obtain a sample of your own urine in a disposable container. Take your module for CLINITESTING URINE and ACETESTING URINE to your instructor and demonstrate the procedure for each test.

ACTIVITY #3. Bili-Labstix

Directions: Read this material and complete the demonstration for your instructor.

Bili-Labstix is a firm plastic strip to which are affixed six (6) separate reagent areas for testing for pH, protein, glucose, ketones, bilirubin, and blood in urine.

Explanations and expected values of each reagent area.

1. pH: pH expresses the degree to which a solution is acidic or alkaline. The pH 7.0 indicates neutral. Both the normal and abnormal urinary pH is from 5 to 9.

2. Protein: Normally no detectable protein is present in urine. Proteinuria (protein in urine) will indicate disorders and/or a disease of the urinary system.

3. Glucose: Normally no detectable glucose is present in urine. Presence of glucose may signify the development of diabetes mellitus. REMEMBER, glucose present in urine may be only temporary because of excess ingestion of sugar, which the body cannot immediately use.

4. Ketones: Normally no ketones are present in urine. In starvation diets or in other abnormal carbohydrate metabolism situations, ketones will be present in the urine.

5. Bilirubin: Normally no bilirubin is detectable in urine but a very small amount may be found in the earliest phases of liver disease.

6. Blood: Normally no blood is present in the urine. Hematuria (blood in the urine) may be symptomatic of a disease or injury to a part of the urinary system.

The test results of the Bili-Labstix may provide information regarding acid base balance, carbohydrate metabolism and indications of kidney and liver function.

LEARNING ACTIVITIES - continued

Procedure for Bili-Labstix Urine

PROCEDURE: BILI-LABSTIX URINE	DEMONSTRATION/COMMENTS
1. *Collect equipment: Reagent strip.	1. ______
2. Collect fresh urine specimen in a clean container.	2. ______
3. Completely immerse all reagent areas of strip in the urine and remove immediately.	2. ______
4. Tap edge of strip against side of urine container to remove excess urine.	4. ______
5. Hold the strip in a horizontal position to prevent possible mixing of chemicals from adjacent reagent area.	5. ______
6. Compare test areas closely with corresponding color charts on the bottle label at the time specified. HOLD STRIP CLOSE TO COLOR BLOCKS AND MATCH CAREFULLY. (ACCURATE TIMING IS ESSENTIAL TO PROVIDE RELIABLE RESULTS.)	6. ______
7. Report results of Labstix to the nurse in charge immediately.	7. ______

*Be sure to close bottle cap tightly after removing strip.

ACTIVITY #4. Keto-Diastix

Directions: Read this material and complete the demonstration for your instructor.

Keto-Diastix is a firm plastic strip to which are affixed reagent areas for testing for ketones and glucose.

Normally no glucose or ketones are present in the urine. This test will provide information on carbohydrate metabolism.

LEARNING ACTIVITIES - concluded

Procedure for Keto-Diastix

PROCEDURE: KETO-DIASTIX	DEMONSTRATION/COMMENTS
1. *Collect equipment: Keto-Diastix.	1. ____________________
2. Collect a fresh urine specimen in a clean container.	2. ____________________
3. Completely immerse reagent areas of the strip in FRESH urine and remove immediately.	3. ____________________
4. Gently tap edge of strip against side of container to remove excess urine.	4. ____________________
5. Compare reagent side of strip to appropriate color block located on bottle label.	5. ____________________
a. Ketones - exactly 15 seconds after removing strip from urine, compare reagents side of strip to the closest matching block. (Original color of reagent area is buff. Disregard color changes that occur after 15 seconds.)	5a. ____________________
b. Glucose - exactly 30 seconds after removing strip from urine compare reagent side of strip to the closest matching color block. (Original color of reagent area is light blue. Disregard color changes that occur after 30 seconds.)	5b. ____________________
6. Report results of Keto-Diastix to the nurse in charge immediately.	6. ____________________

*Replace cap immediately and tightly after removing reagent strip. Do not touch test area of the strip.

unit 8

NURSING ASSISTANT SKILLS

Module I - Reproductive System: Use of the Vaginal Douche for Female Hygiene

RATIONALE

This module will help you learn the correct techniques and procedures for giving a vaginal douche. This is sometimes called a vaginal irrigation.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the purposes for giving a vaginal douche.
2. Demonstrate the procedure for giving a vaginal douche or vaginal irrigation.

LEARNING ACTIVITIES

Directions: All of the information you need to complete this module is included. You will be asked to demonstrate the procedure for giving a vaginal douche. If you need help, your instructor is available. View the Trainex "On Vaginal Douche" if available.

ACTIVITY #1. The Vaginal Douche

Directions: Read the following information.

A vaginal douche, sometimes called a vaginal irrigation, is the regulated flow of solution into the vaginal canal. The solution should always be ordered by the physician. He may order a plain-water or a sterile-water solution. Sometimes, he prescribes a solution with medication in it.

The douche may be ordered by the doctor for many reasons such as:

1. To cleanse the vaginal tract
2. To prepare the patient for surgery or as a treatment after surgery
3. To prevent or treat infection
4. To relieve inflammation
5. To reduce an irritating discharge

A douche is never given to a patient who is menstruating or who is pregnant. Discharged material in the vagina may be forced up into the uterus as you irrigate the vagina. If you are asked by the nurse in charge to give your patient a douche and the patient tells you that she is menstruating or that she may be pregnant, tell the nurse and ask if you should go ahead with the treatment.

LEARNING ACTIVITIES - continued

Exercise 1.

Directions: Answer these questions by circling your answer or by filling in the blanks. Answers can be found in the preceding information.

1. A vaginal douche is the same as a vaginal irrigation. TRUE FALSE
2. The nurse may ask you to give the patient a douche if the patient says she wants one and always does it at home. TRUE FALSE
3. The douche solution is always ordered by the physician. TRUE FALSE
4. Plain water is never used to give douches; the water must always be sterile. TRUE FALSE
5. You may give a douche to a patient who is menstruating to clean out the blood clots. TRUE FALSE
6. List three reasons why a physician may order a douche.

   a. ______________________________

   b. ______________________________

   c. ______________________________

Exercise 2.

Directions: Watch a demonstration given by your instructor on Giving a Vaginal Douche or view the Trainex, Vaginal Douche.

Procedure for Giving a Vaginal Douche

Directions: Read the following procedure. When you demonstrate a vaginal douche, your instructor will check off these steps as you accomplish them.

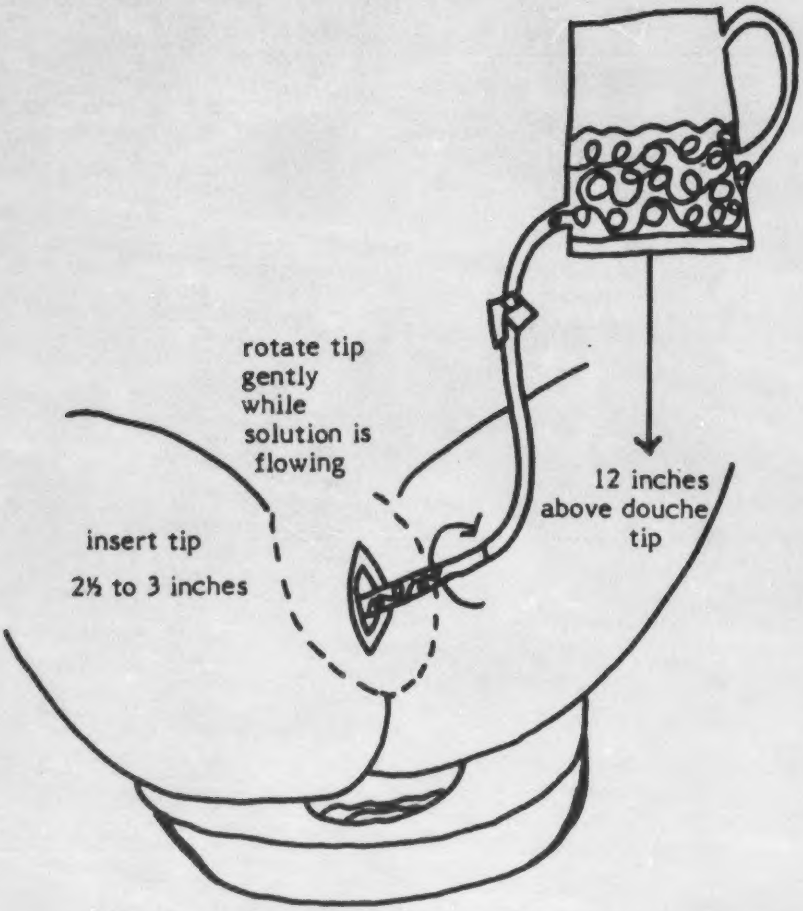
PROCEDURE: GIVING A VAGINAL DOUCHE	DEMONSTRATION/COMMENTS
1. Wash your hands and assemble the following equipment: graduated douche bag or pitcher, tubing and a douche tip, lubricant, solution ordered by the physician, gloves, washcloth and towel, soap, pan of warm water, bedpan.	1. ____________________
2. Identify the patient and explain procedure to her.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: GIVING A VAGINAL DOUCHE	DEMONSTRATION/COMMENTS
3. Set up the equipment and prepare the solution. Solution (1000cc - 1500cc) should be warmed to 105° F.	3. ______________
4. Screen the patient. Put her on the bedpan and drape her.	4. ______________
5. Put on gloves. Clean the perineal area. (See Module G on GIVING PERINEAL CARE.)	5. ______________
6. Lubricate the douche tip and expel air from the tubing. Insert douche tip gently downward and backward into the vagina about 2½ to 3 inches. If the patient is able, she may prefer to insert the tip herself.	6. ______________
7. Lift the douche bag or pitcher to not more than 12 inches above the tip and regulate to gentle flow.	7. ______________
8. Move douche tip forward and backward along the vaginal tract and rotate the tip gently while solution is flowing.	8. ______________
9. Leave about 100cc of solution in the bag, then remove the tip and spray solution over the genitalia.	9. ______________
10. Allow patient to sit on bedpan for 5 to 10 minutes.	10. ______________
11. Clean the equipment and discard or save at bedside table for further treatments.	11. ______________

See illustration on next page for steps number 6 through 9.

LEARNING ACTIVITIES - concluded


rotate tip gently while solution is flowing
12 inches above douche tip
insert tip
2½ to 3 inches

ACTIVITY #2. Giving a Vaginal Douche

Directions: Using the information and following the procedure in this module, practice giving a vaginal douche to Mrs. Chase, the mannequin, as your patient. When you know the procedure for giving a vaginal douche, demonstrate it to your instructor.

NURSING ASSISTANT SKILLS

Module J1 - Levels of Consciousness

RATIONALE

When you are caring for a patient, you are acting as the eyes and the ears of the physician. What you observe and report is of prime importance in the patient's treatment. As you learn to assess the patient's state of consciousness and report this accurately, you will be assisting the doctor in determining the needs of the patient.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the levels of consciousness.
2. Identify characteristics for each level of consciousness.
3. Identify reasons why a change in the level of consciousness may be observed.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this part of Module J is included. Read the information and answer the questions. If you need help, ask your instructor.

ACTIVITY #1. Levels of Consciousness

Directions: Read this material.

Consciousness is the ability to observe, understand, and respond to the environment in an appropriate manner. Consciousness is controlled by the brain and the involuntary nervous system.

There are four levels of consciousness:

1. alertness
2. restlessness
3. stuporous
4. comatose

Certain characteristics describe each level. When you report that your patient is in a particular level of consciousness, you must substantiate (to verify) your decision with observations about your patient that made you reach that decision.

The alert patient is aware of what is going on and reacts to factors in the environment appropriately. The patient is well oriented and can answer questions correctly.

LEARNING ACTIVITIES - continued

The restless patient is very sensitive to factors in the environment and often exaggerates responses to questions and to situations. He may be combative, toss and turn in bed, or twitch and pick at the air, or at the clothes. He may be very, very anxious or depressed. When asked simple questions, the restless patient is usually able to answer but may respond sharply or cry inappropriately. He is usually confused.

The stuporous patient lies quietly in bed and seems to be sleeping; he is lethargic or very drowsy and may seemingly fall asleep in the middle of a sentence. However, he can be aroused by calling to him -- even the simple opening of the eyes -- is a response. He will respond to pain by moaning or withdrawing from the painful stimulation. He is confused and disoriented, and may be incontinent.

The comatose patient lies quietly in bed and appears to be sleeping. He cannot be aroused and will not respond to verbal or painful stimulation.

Exercise.

Directions: Answer these questions by filling in the blanks. Answers can be found on page 4 of this module.

1. Consciousness is the ability to respond to the environment in an ______________ ________________.
2. Name the four levels of consciousness:
   a. ________________________________
   b. ________________________________
   c. ________________________________
   d. ________________________________
3. When you visit Mr. Jones, you find him picking at the "flies" in the air and then "flicking" them at you when they are caught. He suddenly doubles up in obvious pain but when you ask him if he needs medication for pain, he yells, "NO!!! I'm not in pain!!" Mr. Jones is in what level of consciousness? ________________ ________________.
4. You walk in on Mrs. Beetle to find she has wet the bed for a second time. When you call out her name, she smiles sweetly and says "Yes, dear," but falls back to sleep. You have not been able to keep her awake all morning. What level of consciousness is Mrs. Beetle in? ________________________.
5. You tell the nurse in charge that your patient is comatose. He asks you what made you decide that. What do you tell the nurse?

NURSING ASSISTANT SKILLS

Module J2 - Neurological Signs

RATIONALE

Neuro signs are special checks or observations made on patients with nervous system disorders. These checks help to tell us if the patient's condition is changing. You will be asked to check neuro signs and to report all observations.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate the procedure for checking neuro signs.
2. Identify the neuro signs that are normal and abnormal.

LEARNING ACTIVITIES

Directions: Read the information in this part of Module J and answer the questions at the end of each section. You will be asked to demonstrate checking neuro signs as you care for patients in the clinical area. If you have any questions, ask your instructor for help.

ACTIVITY #1. Neurological Signs

Directions: Read this information.

Measurement of neurological signs is done to provide clues to a change in the patient's condition. Neuro signs are measured at periodic intervals as ordered by the physician. They are usually done at the same time as the vital signs.

To check neuro signs, you must make the following observations:

1. Pupil Response. Ask your patient to open the eyes and observe the pupils for size. Are both pupils equal in size? If unequal, be sure to note which pupil is dilated or larger. Then, turn off the overbed light and have your patient look straight ahead. Using a lighted flashlight, shine the light in each eye bringing it over the eye from the side of the head. Notice if the pupils constrict or get smaller in response to the light.

   Normal: Pupils are equal and react to light by constricting.

   Abnormal: Pupil reacts slowly to light.
   Pupil does not react to light.
   Pupil dilated at all times.
   Pupil pinpoints and does not react to light.
   Pupil reacts to light by dilating.

LEARNING ACTIVITIES - continued

2. Tongue. Ask your patient to stick out the tongue. Is she able to follow your directions or does the tongue curl up in the mouth? Does the tongue protrude straight out or does it deviate to one side of the mouth?

   Normal: Tongue midline.

   Abnormal: Unable to extend tongue.
   Tongue deviates to right or left side.

3. Movement of Extremities. Have your patient lift both arms and hold them in position. Is she able to maintain that position? Drifting downward or wobbling is a sign of beginning weakness. Then, test hand grips by having the patient squeeze the first two fingers on both of your hands. Test the grips on both the right and left hands at the same time. Determine whether the grip is equal in both hands and if it is strong.

   Normal: Able to lift both arms and maintain position.
   Hand grip is strong and equal in both hands.

   Abnormal: Unable to lift arms.
   One arm or both arms drift downward or wobble when lifted.
   Unable to grasp with one hand or both hands.
   Grasp is weaker in one hand.

To check the movement in the legs, have your patient raise both legs, one at a time. She should be able to raise both legs to the same height. When the palms of your hands are placed against the soles of the patient's feet, she should be able to press against your hands with equal strength.

Normal: Able to lift both legs to the same height.
Strong and equal push from both feet.

Abnormal: Unable to lift both legs to the same height.
Unable to lift leg.
Unable to push with one foot or both feet.
Push is weaker in one foot.

Exercise.

Directions: Using the list below, indicate the letter "N" for "normal neuro signs" or the letter "A" for "abnormal neuro signs". Check your answers with the information found in the preceding pages.

1. _____ Pupils equal.
2. _____ Both pupils react to light.
3. _____ Right pupil fixed in size.
4. _____ Pupils of unequal size.
5. _____ Patient has double vision.

LEARNING ACTIVITIES - concluded

6. _____ Right pupil reacts sluggishly.

7. _____ Grasps unequal.

8. _____ Grasps equal.

9. _____ Both legs raised to same height.

10. _____ Right leg is stronger than the left leg.

11. _____ Tongue is midline when extended.

12. _____ One leg is stronger that the other leg when pressed against hand.

13. _____ Tongue deviates to right side.

14. _____ Right arm drifts down when lifted.

15. _____ Pupils react to light by dilating.

ACTIVITY #2. Demonstration

Directions: Using another student as your patient, demonstrate to your instructor how you would check neuro signs. Report your observations to your instructor.

NURSING ASSISTANT SKILLS

Module J3 - Seizure Precautions

RATIONALE

At sometime in your career, either as a citizen or while working in a health care facility, you may encounter someone who is having a seizure. As a member of the health team, you will need to know what to do in order to protect these individuals from harming themselves.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the grand mal and the petite mal seizure.
2. Identify and practice important safety precautions during a convulsion.
3. Identify observations you will make during a seizure.

LEARNING ACTIVITIES

Directions: Read the information in this part of Module J and answer the questions at the end of each section. You will be asked to practice the safety precautions as you care for epileptic patients. If you have any questions, STOP, and ask your instructor for help.

ACTIVITY #1. Types of Seizures

Directions: Read the following information.

Epilepsy is a word meaning "seizure". A common lay term for seizures is "fit". A seizure involves a temporary disturbance in consciousness which may or may not be accompanied by convulsions. Convulsions are involuntary, uncontrolled muscular contractions and relaxations. There are many different kinds of seizures or epilepsy. Two of the most common are:

1. GRAND MAL EPILEPSY. In this type of epilepsy, the patient suddenly cries out and falls unconscious to the ground. At first, the whole body is rigid in spasm and then the patient may thrash in violent jerks. He will temporarily stop breathing and may become very cyanotic. The patient may bite the tongue and void incontinently before the seizure stops. After the seizure, the patient usually has no memory of the attack. The body and clothing are wet with heavy perspiration and he may experience generalized muscular pain and soreness. Often, he complains of headaches and exhaustion and frequently sleeps for several hours.

LEARNING ACTIVITIES - continued

2. PETIT MAL EPILEPSY. Petit mal seizures more commonly afflict children than adults. This type of epilepsy is characterized by brief losses of consciousness, sometimes accompanied by twitching of the hands, face, or eyes. The patient may have a blank stare that lasts only a few seconds; or may suddenly stop in the middle of a sentence and then continue where he left off. These seizures may occur many times during the day and may be so brief that they go unnoticed. The child may even be unaware of them.

Exercise.

Directions: Answer these questions pertaining to types of seizures by filling in the blanks or by circling TRUE or FALSE. Answers may be found in the preceding information.

1. Write the definition for the following vocabulary words:

   Epilepsy: ______________________________

   Seizure: ______________________________

   Convulsions: ______________________________

2. The two most common types of seizures are __________ _____ epilepsy and ________ ____ epilepsy.

3. A convulsion is a voluntary muscle contraction. TRUE FALSE

4. If the patient having an epileptic seizure should stop breathing and become cyanotic, you must call a CODE ARREST. TRUE FALSE

5. During a seizure, the patient may bite the tongue? TRUE FALSE

6. Petit mal epilepsy is more common in adults. TRUE FALSE

7. A person having a petit mal seizure might be unaware that she is having a seizure. TRUE FALSE

8. At the beginning of a grand mal seizure, the patient may become rigid, cry out, and fall unconscious to the ground. TRUE FALSE

9. After a seizure, the patient may complain of headaches, but if she wishes to sleep, she must be awakened every half hour to make sure she did not suffer any head injury. TRUE FALSE

ACTIVITY #2. Seizure Precautions

Directions: Read this material.

If a patient is admitted to a health care facility with a diagnosis of epilepsy or convulsions or with a history of epilepsy, although controlled, you must practice certain safety precautions to prepare for a possible seizure.

1. If the patient is to remain in bed, keep the siderails up at all times. Siderails must be padded.

LEARNING ACTIVITIES - continued

2. Tape a padded tongue blade to the head of the bed.

3. Always accompany the patient when he goes to the bathroom and wait for him to finish. The bathroom is one of the most dangerous places for the epileptic to have a seizure. He may hit his head against the bathtub, sink, or toilet as he falls and may continue to injure himself as he thrashes in the confined space.

Nursing care of the patient during a seizure is aimed toward preventing the patient from harming himself. Important safety precautions include:

1. ALWAYS STAY WITH THE PATIENT. You may turn the emergency flashes on to get help but never leave the patient. Most convulsions last only about three minutes and will be over before you return if you do leave to seek help. If no one is there to protect him, the patient may injure himself. Also, you must be with the patient to observe and report the necessary information concerning the seizure.

2. Place the padded tongue blade or any soft object such as a washcloth between the front top and bottom teeth to prevent the patient from biting his tongue. Never use your finger -- it will be bitten!!! Do not force the tongue depressor between the teeth if the patient has already clamped his teeth.

3. Do not try to move the patient until the convulsion is over unless he has fallen on or near something dangerous.

4. The head should be protected from striking any hard surface but do not attempt to restrain the patient's movements.

5. Loosen any tight clothing especially around the neck area.

6. Discourage spectators. The patient is not a spectacle.

ACTIVITY #3. Seizure Observations and Recordings

Directions: Observe and report important information concerning the seizure such as:

1. The time the seizure started and ended. Time the length with your watch. Do not try to estimate -- it will probably seem like hours to you.

2. The body parts involved and the type of muscular contractions. Did the muscles become rigid, or did they jerk in alternate contractions and relaxations?

3. Whether the patient lost consciousness and for how long.

4. The appearance of the pupils. Were they dilated or constricted?

5. Whether the patient was incontinent during the seizure.

6. Injury that occurred during the convulsion.

7. The patient's response after the seizure. Did she remember the attack? Was she well oriented? Did she complain of headache? Was she sleepy?

LEARNING ACTIVITIES - concluded

Exercise.

Directions: Answer the following questions by filling in the blanks and/or circling TRUE or FALSE. Answers may be found in the preceding information.

1. The nurse in charge tells you that you will soon be admitting a patient with epilepsy. You prepare the patient's unit by doing what two things?

   a. ______________________________

   b. ______________________________

2. When your patient starts to have a seizure, you must always get help even if you have to run down to the nurse's station or scream out into the hall.
   TRUE FALSE

3. If the patient is banging her arm against a chair during a seizure, you should attempt to restrain her arm. TRUE FALSE

4. You may place a padded tongue blade or washcloth between the patient's front teeth but if she has already clamped her teeth down, do not try.
   TRUE FALSE

5. If the patient has fallen on the floor during a seizure, you should get help to try and move him into bed. TRUE FALSE

6. You must always stay with the patient during a seizure even if help never comes.
   TRUE FALSE

7. You must observe the pupils of a patient during the convulsion. They are usually larger or ______________ but they may also be very small or ______________.

8. Besides the pupils, list six other observations of a patient during the convulsion that you will be responsible for in reporting.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

   f. ______________________________

unit 8

NURSING ASSISTANT SKILLS

Module J4 - Protective Restraints

RATIONALE

In your work as a nursing assistant, you will meet patients who need to be restrained to protect them from injuring themselves. This module will familiarize you with the various kinds of restraints and the indications for their use.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify reasons for restraining a patient.
2. Recognize the different types of restraints.
3. Demonstrate the application of protective restraints.

LEARNING ACTIVITIES

Directions: Read the information in this part of Module J and answer the questions at the end of the section. You will be asked to practice applying protective restraints as you care for patients in the clinical area. If you have any questions, STOP, and ask your instructor for help.

ACTIVITY #1. Care of the Patient Needing Protective Restraints

Directions: Read this information.

Protective restraints are ordered by the physician to limit the activity of a patient. He may decide to restrain the patient for the following reasons:

1. To protect the patient from herself
2. To protect others working with the patient
3. To protect an important medical treatment

ACTIVITY #2. Different Types of Restraints

Directions: Read the following material.

There are two types of restraints: soft restraints made of linen or muslin and hard restraints made of leather. Some specific examples of the protective restraints include:

1. Waist restraint or safety belt. May be either soft or hard; allows the patient to roll from side to side and to sit up in bed.

LEARNING ACTIVITIES - continued

2. Posey restraint or chest harness. A soft restraint; limits movements from side to side and limits sitting up.

3. Arm and leg restraints. May be either soft or hard; limits the movement of arms and legs; may be turned from side to side and restrained.

4. Mummy restraint. A soft restraint; limits all movement; arm and legs held close to the body.

ACTIVITY #3. Application of Protective Restraints

Directions: To safely and comfortably restrain a patient, remember these principles. Demonstrate them to your instructor.

1. Explain the purpose of the restraint to the patient. You may need to give the patient frequent explanations. The patient who is restrained may be very restless and fearful. Your attention and careful explanations may help alleviate some of the anxiety.

2. Always raise the bed rails after the restraint is applied.

3. When securing a restraint, tie it to the bed frame, not to the side rails. The patient can easily reach over and untie a restraint attached to the bed rail.

4. When applying an arm or leg restraint, you should be able to insert one finger between the restraint and the skin. This will insure that the restraint is tight enough to stay in place without impairing circulation.

5. Remove the restraints every two hours to examine the skin for any irritation and to check for impaired circulation.

6. Do ROM exercises while the restraint is off and then reapply the restraint. (ROM = Range of Motion, Remember? See Module B.)

7. Change the patient's position at least every two hours. A patient with arm and leg restraints should NEVER be restrained "spread eagle". Restrain the patient first on one side, than on the other.

8. Before restraining for the night, make sure the patient has used the bathroom. Falls from the bed most often occur when the patient is trying to get to the bathroom at night. Check the patient frequently both night and day for incontinence or retention. Ask her if she needs to void or position the urinal or the bedpan every two hours for use.

9. Check the patient frequently to see that she is comfortable and that the restraint is in place.

Exercise 1.

Directions: Using another classmate, demonstrate the application of a jacket restraint, ankle restraint, and wrist restraint. Have the instructor check your procedure.

LEARNING ACTIVITIES - concluded

Exercise 2.

Directions: View the Trainex, The Use of Protective Restraints. If you cannot locate the Trainex or equipment needed to view the Trainex, ask your instructor to assist you. After you have viewed the Trainex, answer the following questions by filling in the blanks or by circling TRUE or FALSE. Answers can be found on page 4 of this module.

1. A doctor does not need to order protective restraints. The nurse may apply them if she sees that it is necessary without ever consulting the doctor for an order. TRUE FALSE
2. A restraint applied to the waist that allows the patient to roll from side to side is the __________ restraint.
3. A chest harness is the same thing as a _________________ restraint and limits side to side movement.
4. All movements are limited when using the ________________ restraint.
5. Most patients needing to be restrained are confused and an explanation of why they are being restrained never helps. TRUE FALSE
6. Where do you tie the restraint when attaching it to the bed? ______________
7. Restraints should be removed every ______ hours and ROM exercises done.
8. How would you check an arm restraint to know that it is not too tight but tight enough to restrain? ___________________
9. How frequently do you change the patient's position when she is restrained?
   ____
10. Always make sure the patient has voided before restraining him for the night. TRUE FALSE

ANSWERS

ACTIVITY #3

1. FALSE
2. waist restraint or safety belt
3. posey
4. mummy
5. FALSE
6. tie it to the bed frame, NEVER to the side rails
7. 2
8. insert one finger between the restraint and the skin
9. at least every two hours
10. TRUE

NURSING ASSISTANT SKILLS

Module K1 - Preoperative Nursing Care

RATIONALE

As you care for patients in a health care facility, you may be asked to help a patient get ready for surgery even though you may not work on a surgical floor. This module will help you to learn the routine procedures for preparing a patient for surgery.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify and record the procedures for patient's pre-op preparation.
2. Demonstrate and identify the procedures for preparing a patient immediately prior to surgery.

LEARNING ACTIVITIES

Directions: This is the first part of Module K. There are five other parts, so GET BUSY. Read all of the material and answer all of the questions. You will be asked to demonstrate the procedures for preparing a patient for surgery as you care for patients in the health care facility. If you need any help, your instructor is available.

ACTIVITY #1. Preparation the Evening Before Surgery

Directions: Read this information.

The word "preoperative" is a word meaning "before surgery". Pre = before and operative = surgery.

Preoperative nursing care is the care given a patient before surgery to prepare him for the operation.

Most surgical procedures are scheduled by the physician through the operating room nurse and are performed in the morning. Usually, the patient will be admitted to the health care facility the evening before a scheduled operation so that he will be adequately prepared and well rested before the morning of surgery.

Many patients are admitted to the health care facility for diagnostic procedures such as blood tests, stool or urine specimens, and x-rays. After studying these tests, the physician may then decide that the patient will need surgery. There are several procedures you may be asked to do for a patient on the afternoon or evening before surgery to help to prepare him for an operation. These procedures are listed for you.

1. Take the patient's TPR and blood pressure and carefully check for any symptoms of a respiratory infection, such as sneezing, coughing, complaints of chest pain, or high temperature. Since one of the major complications of surgery is

LEARNING ACTIVITIES - continued

pneumonia, the operation may be postponed if the patient shows signs of respiratory infection. Also, a change in the patient's TPR or blood pressure may temporarily cancel the surgery.

2. Collect a routine urine specimen and send it to the laboratory.

3. Tell the patient about the special restrictions on taking food or liquids. Usually, the patient is not allowed solid food for 12 hours before surgery and no liquids for six to eight hours before the operation. Read the doctor's orders and tell the patient what limitations the doctor has ordered. The physician may have ordered "NPO p̄ 2400" which means that the patient can have nothing by mouth after midnight. He may order "NPO p̄ liquids breakfast at 0600" and this means that the patient can have no solid foods but will receive a liquid breakfast at six in the morning; he cannot have any other liquids after six.

4. Post an "NPO" sign to remind the patient and others of any dietary restrictions. The sign should include the patient's name, date, and specific instructions as "NPO p̄ 2400 for surgery". Remember to take the patient's water pitcher and glass away at midnight if he is to be NPO after midnight.

5. Do any special treatments that are ordered by the physician. An enema, a Phisohex or a betadine shower may be ordered the evening before the operation. Be sure to explain any treatments to the patient and why they are being done.

6. The patient will be asked to sign a consent for surgery. The nurse in charge is usually responsible for having the patient sign the consent and for witnessing the signature. The patient must thoroughly understand the operation to be performed and some of the possible complications after surgery. The patient must read the entire consent or the nurse must read it to him. The consent must then be signed by the patient, witnessed by the nurse, dated, and timed for the time it was signed. An example of a consent for surgery is on the following page. The patient may ask you about the operation. Do not ignore the questions. Answer the questions you feel sure about. Tell the patient that you will ask the nurse or doctor to come to answer questions since they know more about the medical condition.

7. Tell the patient some of the things to expect after surgery. He may be awakened frequently to have the vital signs checked. He will be asked to turn and move the legs in bed at least every two hours. Demonstrate how he can place the pillow over the incision site and tightly press the pillow against the body with the arms. You will then instruct him to cough deeply to remove any secretions from the lungs. Tell him that he may be asked to dangle in bed or get up in a chair very early after surgery -- maybe the same night or the next day. Practice the procedure for dangling so that he will be better prepared to cooperate.

8. Ask the female patient to remove any colored nail polish and ask her not to apply any cosmetics in the morning. During surgery, the physician will need to see the true color of the patient's skin and nails to observe any changes in her condition.

Nearly every patient who enters the health care facility for an operation will be somewhat nervous and upset. Adequate pre-op preparation before the surgery will help relieve some of these anxieties.

LEARNING ACTIVITIES - continued

CONSENT TO OPERATION, ADMINISTRATION OF ANESTHETICS, AND THE RENDERING OF OTHER MEDICAL SERVICES

Date ________________

Hour _______ ____ M.

____
Name of Patient

1. I authorize and direct ________________________________ M.D. my surgeon and/or associates or assistants of his choice to perform the following operation upon me __________________________________ and/or to do any other therapeutic procedure that (their) judgment may dictate to be advisable for the patient's well-being. The nature of the operation has been explained to me and no warranty or guarantee has been made as to the result or cure.

2. I hereby authorize and direct the above named surgeon and/or his associates or assistants to provide such additional services for me as he or they may deem reasonable and necessary, including, but not limited to, the administration and maintenance of the anesthesia, and the performance of services involving pathology and radiology, and I hereby consent thereto.

3. I understand that the above named surgeon and his associates will be occupied solely with performing such operation, and the persons in attendance at such operation for the purpose of administering anesthesia, and the person or persons performing services involving pathology and radiology, are not the agents, servants or employees of the above named hospital nor of any surgeon, but are independent contractors and as such are the agents, servants, or employees of myself.

4. I hereby authorize the hospital pathologist to use his discretion in the disposal of any severed tissue or member, except ________________________.

Patient's Signature ________________________________

Witness ________________________________

(If patient is a minor or unable to sign, complete the following:)

Patient is a minor _______________, or is unable to sign, because _______________

____.

FATHER	GUARDIAN
MOTHER	OTHER PERSON AND RELATIONSHIP

LEARNING ACTIVITIES - continued

ACTIVITY #2. Preparation the Morning of Surgery

Directions: Read the following material.

The nurse in charge may ask you to prepare a patient the morning of surgery. Remember, the patient is scheduled for surgery that morning and she must be properly prepared before surgery. Her care will require your attention first and you must work quickly. However, do not make the patient feel rushed or hurried.

Preparation includes:

1. Ask the patient to bathe and brush her teeth and assist her as necessary. Remind her not to swallow any water when she brushes the teeth. The patient should be dressed in a clean hospital gown - no pajama bottoms or underwear.

2. You may be asked to complete part of the pre-op checklist. The pre-op checklist is a special check to make sure that the patient and the patient's chart is properly prepared before the patient goes to surgery. An example of the checklist is at the end of this reading material.

3. Take the patient's TPR and blood pressure and record them on the pre-op checklist, if required. Report any changes in the vital signs to the nurse immediately.

4. Ask the patient to remove all jewelry except rings. Rings may be taped to the patient's finger with tape or a bandaid. If relatives are with the patient, give all of the jewelry to them for safekeeping. If no relatives are present, ask the nurse in charge what the policy of the facility is for caring for jewelry.

5. Ask the patient to remove all hairpins.

6. All of the following items must be removed, labeled with the patient's name and room number, and put in the proper place:

    a. Dentures and removable bridges. These must be placed in a labeled denture cup and put in the drawer of the bedside table. In some facilities, the patient is asked to leave the dentures in for surgery; check with the nurse in charge concerning the facility's policy.

    b. Eye glasses and contact lenses. These must also be labeled and placed in the bedside table.

    c. Artificial limbs. Label these and store them in the patient's closet.

    d. Artificial eyes, hair, eyelashes. Label and put in the bedside table.

    e. Hearing aides. Label and place in the drawer of the bedside table unless otherwise instructed by the doctor.

    f. Crutches and walkers. Label and store in the patient's closet.

LEARNING ACTIVITIES - continued

7. The patient will probably receive a preoperative medication that is designed to induce relaxation before surgery. The nurse will tell you when the medication is to be given. Fifteen minutes before the patient receives pre-op medication, you must help him to the bathroom to empty the bladder. He must then remain in bed with the side rails up. Fifteen minutes after pre-op medication is given, you must again check the pulse, respirations, and blood pressure. Report any changes to the nurse in charge and record these on the pre-op checklist as required.

EXAMPLE OF PRE-OP CHECKLIST

FLOOR NURSES CHECKLIST | OPERATING ROOM NURSES CHECKLIST

1. Prep completed by ____________
2. Consent for Surgery ____________
3. Sterilization permit ____________
4. History & Physical (circle one)
   Dictated
   Not dictated
   On chart
5. Blood report on chart ____________
6. Urinalysis report on chart ____________
7. Type & cross match ____ Units ____________
8. Identification bracelet checked ____________
9. Allergies: ________ ________
   ________ ________
10. Voided ________ Time ____________
    (yes or no)
11. Retention catheter ____________
    (yes or no)
12. Morning TPR recorded ____________
13. Blood pressure recorded ____________
14. Pre-op medication given ____________
15. Blood pressure recorded after
    Pre-op medication ____________
16. Dentures: ____________
    None ____________
    Type ____________
17. Prosthesis:
    Type ____________
    Disposition ____________
18. Jewelry ____________
    (yes or no) ____________
    Disposition ____________

PROCEDURE COMPLETED

Signature ____________________

OTHER INFORMATION

Date ____________

PRE-OP CHECKLIST

Signature ____________

LEARNING ACTIVITIES - concluded

Exercise.

Directions: Answer the following questions by filling in the blanks or by circling "TRUE" or "FALSE". Answers can be found in the preceding information.

1. The word "preoperative" is a word meaning "____ ___________".

2. You should report any preoperative symptoms of respiratory infection to the nurse in charge. List four symptoms to observe for.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

3. Observing for possible respiratory infection is important because ____________ ______________ is a major postoperative complication.

4. You will be asked to collect a specimen the evening before surgery. What type of specimen will you collect? ______________________________

5. Your patient asks you how long he will be in the operating room. What will you tell him? ______________________________

6. The physician has ordered that the patient be "NPO $\bar{p}$ 2400". What will you tell the patient about the dietary restrictions? ______________________________

7. You ask your patient to remove the nail polish and she protests, "But I just painted them before coming to the hospital". How will you explain why this is necessary? ______________________________

8. On the morning of surgery, the patient is asked to void. When should this be done? ______________________________

9. Before surgery, dentures should be removed, wrapped in a clean paper towel, and placed in the patient's bedside stand. TRUE FALSE

10. Hearing aides may be left in place so that the patient may hear in order to follow instructions in the recovery room. TRUE FALSE

NURSING ASSISTANT SKILLS

Module K2 - Postoperative Nursing Care

RATIONALE

You may be asked to care for a patient who has just returned from surgery. Your careful observations and skilled care are essential to insure that the patient will quickly recover from surgery with as few complications as possible.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate and identify the procedures for giving postoperative care.
2. Recognize possible complications of postoperative care.
3. Identify turn, cough, and deep breathe procedures.

LEARNING ACTIVITIES

Directions: Read the information and answer the questions at the end of this part of Module K. You will be asked to view the Trainex, Preoperative and Postoperative Care. If you have any questions, please ask your instructor for help.

ACTIVITY #1. Postoperative Nursing Care

Directions: Read this information.

The word "postoperative" is a word meaning "after surgery". "Post" = after and "operative" = surgery. Postoperative nursing care is the care that is given a patient after returning from surgery.

After a patient has had an operation, she usually spends time in the postoperative recovery room before returning to the unit. When the patient comes back to the room, you will be asked to care for her and to observe her very carefully.

1. Prepare the patient's unit for return. Make a post-op or surgical bed. Remember to have an I.V. pole ready at the bedside. Hang an I & O sheet in the room. Put tissues and an emesis basin on top of the bedside table. Remember the patient will be coming back on a stretcher. Make sure the bedside area is clear of furniture so that the stretcher can be easily moved next to the bed.
2. When the patient returns to the room, help move her from the stretcher onto the bed. Raise the side rails after she is in bed. Unless told not to, raise the head of the bed slightly.

LEARNING ACTIVITIES - continued

3. Take the patient's TPR and blood pressure immediately. Report to the nurse in charge if the patient's:

   a. pulse is slow - below 60

   b. pulse is fast - above 100

   c. respirations are labored and rapid - above 30

   d. respirations are depressed - below 12

   e. blood pressure is high or low - check to see what the patient's blood pressure was before surgery.

   The physician will order that the vital signs be checked at periodic intervals, perhaps every 15 minutes or every hour. Check with the nurse in charge to learn how often you are to take vital signs. If the doctor does not write an order, vital signs are always routinely checked every four hours for 48 hours after surgery.

4. Check the patient's level of consciousness. Call the patient by name. Ask if she knows where she is and tell her if she does not know. If the patient is still very drowsy from the anesthesia, arouse her every 15 minutes and have her deep-breathe and cough until she is more alert and responsive.

5. Encourage the patient to cough and deep breathe every 15 minutes until alert and then at least every two hours. Splint the incision with a pillow to make coughing easier. Encourage the patient to cough deeply - not just from the throat. One of the major complications of surgery is hypostatic pneumonia. This is a pneumonia that develops because the mucus produced during the surgery settles at the base of the lungs and is never adequately coughed up.

6. Unless told not to, turn the patient from side to side at least every two hours. When you turn her, ask her to move her legs in bed. The turning helps the patient to rest more comfortably; it protects the skin and helps to prevent pneumonia. Another postoperative complication is the development of blood clots or thrombi in the veins of the legs. Asking the patient to exercise the legs in bed will help increase the circulation in the legs and prevent this complication.

7. The postoperative patient will have intake and output measured routinely for at least 48 hours after surgery. If the patient has a Foley catheter, check the catheter to make sure it is unobstructed and draining. Watch the urinary output for amount, color, and odor. If the patient does not have a Foley, always report to the nurse the first time the patient voids. Be sure to measure the urine and check it for color and odor.

8. On the patient's first postoperative day, that is, the first day after surgery, check the patient's abdomen. Feel the abdomen to see if it is distended and firm or hard. Ask the patient if she has started to pass gas or flatus through the rectum. Another possible postoperative complication is paralytic ileus. This is a condition where the normal peristaltic movements are temporarily paralyzed.

LEARNING ACTIVITIES - continued

The patient is unable to pass stool or flatus through the rectum and the intestine becomes very distended with excretions that cannot be expelled.

9. Be very careful to observe:
   a. the I.V. to insure that it is infusing well at the correct flow rate.
   b. the patient's dressings for sudden bleeding or excessive drainage.
   c. the drainage tubes or tubes connected to suction to make sure they are draining properly. Check the color and the amount of the drainage.
   d. signs for hemorrhage. Hemorrhage or an abnormal loss of blood is another postoperative complication.

10. Also observe the patient for:
    a. foley draining or urination within 8 hours after surgery.
    b. a change in the vital signs - rapid pulse, low blood pressure, rapid and irregular respirations.
    c. color of skin, lips, and the fingernails for pale or cyanotic color.
    d. extreme or unusual restlessness.
    e. excessive thirst.
    f. sudden bright red bleeding.

Remember to report all of your observations to the nurse in charge immediately.

Exercise.

Directions: View the Trainex, Preoperative and Postoperative Care and answer these questions by filling in the blanks or by circling TRUE or FALSE. Answers can be found on page 6 of this module.

1. The word "postoperative" is a word meaning "______" "______________".
2. If the doctor does not write an order for vital signs, the vital signs are routinely check how often? ______________________.
3. List five changes in vital signs that you would report to the nurse immediately:
   a. ____
   b. ____
   c. ____

LEARNING ACTIVITIES - continued

d. ______________________________

e. ______________________________

4. If the patient is still very drowsy from the anesthesia, what do you do?

____

5. The patient is routinely encouraged to cough and breathe deeply at least every ____________ hours.

6. A major complication of surgery that happens because the patient does not breathe deeply and cough adequately is __________ ________________.

7. How often do you turn a patient from side to side? __________________

8. Another postoperative complication that may be prevented by encouraging the patient to exercise the legs in bed is _____________ or blood clots in the legs.

9. If the patient complains of pain when she coughs, she should not be encouraged until after the first postoperative day. TRUE FALSE

10. If the patient is voiding well immediately after surgery, the intake and output are not necessarily measured. TRUE FALSE

11. When you check the patient's abdomen to see if it is distended and ask if he is passing gas, you are checking for another postoperative complication called _________ _____________.

12. Another word for gas that is passed rectally is __________________.

13. When you check the patient's tubes that are connected to suction, you are checking the amount and the color of drainage and to make sure that they are draining properly. TRUE FALSE

14. Another postoperative complication is the abnormal loss of blood known as _________________.

15. Of the observations listed below, circle the ones that will indicate that the patient is losing blood abnormally:

   a. rapid, irregular breathing

   b. low pulse

   c. low blood pressure

   d. complains of excessive thirst

   e. is hot and flushed

LEARNING ACTIVITIES - concluded

f. nail beds cyanotic

g. complains of excessive hunger

h. restless

i. fast pulse

ACTIVITY #2. Turn, Cough and Deep Breathe (T.C.D.B.)

Directions: Read the following information.

In order to prevent respiratory complications, it is extremely important to turn, cough and deep breathe any patient returning from surgery. The reasons for each are:

1.	Turning	Circulation is stimulated, deeper breathing is encouraged, and pressure areas are relieved. (The patient is turned every two hours (q2h) from side position to back position to side position.)
2.	Cough	Promotes the removal of chest secretions.
3.	Deep Breathing	Promotes greater lung expansion, supports proper exchange of oxygen and carbon dioxide.

Read the procedure for T.C.D.B. and then demonstrate this procedure for your instructor.

1. Have patient in supine position. Head of bed may be elevated.
2. Patient may splint incision with pillow or bath blanket. Hold pillow firmly over incision area on trunk of body.
3. Instruct patient to take 3 slow, deep breaths. On the 4th inhalation, the patient is to cough (splinting incision if necessary). Any secretions brought up by coughing are to be spit out into tissue or emesis basin (not swallowed). Observe the color, amount, and consistency. This should be repeated 2-3 times every two hours; sometimes more often if patient's condition warrants it. NOTE how patient tolerates procedure.

This procedure is good nursing care on all postoperative patients and any bedrest patient, especially if patient smokes.

Exercise.

Directions: Demonstrate the T.C.D.B. procedure for your instructor using another student as your patient.

ANSWERS

ACTIVITY #1

1. after, surgery
2. every four hours for 48 hours after surgery
3. a. slow pulse - below 60
   b. fast pulse - above 100
   c. respiration labored and rapid - above 30
   d. respirations depressed - below 12
   e. blood pressure - high or low
4. encourage patient to cough and deep breathe
5. 2
6. hypostatic pneumonia
7. at least every 2 hours
8. thrombi
9. FALSE
10. FALSE
11. paralytic ileus
12. flatus
13. TRUE
14. hemorrhage
15. a, c, d, f, h, and i

unit 8

NURSING ASSISTANT SKILLS

Module K3 - Care of Dressings

RATIONALE

Many patients that you will care for will have dressings. As you care for these patients, you must carefully observe and report correctly the approximate amount of drainage and the color of the drainage on the dressing. Your observations will help the nurse in charge to accurately assess the patient's condition and determine his needs.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the purposes for a dressing.
2. Demonstrate checking the patient's dressing regularly for drainage.
3. Describe the drainage on a dressing.

LEARNING ACTIVITIES

Directions: This part of Module K is very short but the information provided is valuable, so read it and learn it. If you have questions, ask your instructor for help.

ACTIVITY #1. Purpose for a Dressing

Directions: Read the following material.

The purpose of a dressing may be:

1. To aid in preventing infection from entering the wound
2. To absorb secretions
3. To protect the area from trauma
4. To apply pressure to promote hemostasis or clotting

ACTIVITY #2. Caring for a Dressing

Directions: Read the following material.

When you care for a patient with a dressing, you will be responsible for checking that dressing at least every two hours. Be sure your hands are clean before doing this. As you observe, be very careful to note the color, consistency, and approximate amount of drainage from the wound as it appears through the dressing. Do not lift the edges of the dressing or remove the dressing to check the drainage. Check what has soaked through to the outside of the dressing.

LEARNING ACTIVITIES - continued

ACTIVITY #3. Drainage Descriptions

Some of the terms which you may use when describing the drainage on a dressing are:

1. Color: pink, red, pink-tinged, serous yellow, golden-yellow, sanguineous (which means bloody), sero-sanguineous (which means bloody mixed with serum so the drainage will have a watery bloody appearance), purulo-sanguineous (which means bloody mixed with pus).
2. Consistency: thick, watery, sticky, tenacious (which means thick and sticky), dry, crusty.
3. Approximate amount: copious, large, profuse, small, scant, slight, moderate.

If the dressing does not show any drainage, it may be described as being clean or dry.

Exercise.

Directions: Answer these questions by filling in the blanks or by circling "TRUE" or "FALSE". Answers can be found in the preceding information.

1. A dressing is never applied to a sterile incision because it will trap bacteria and cause infection. TRUE FALSE
2. If the patient is draining large amounts of bile from an incision, the physician may order a dressing to absorb the secretions. TRUE FALSE
3. A dressing is never applied to an injured area because the area will heal better if exposed to air. TRUE FALSE
4. Dressings may be applied to an injured area to protect the area from further trauma. TRUE FALSE
5. A dressing may be applied to provide pressure to a bleeding area to promote ______________ or clotting.
6. List three observations you will make about the drainage on a dressing.
    a. ____
    b. ____
    c. ____
7. ________________ is a term used to describe bloody drainage.
8. If the drainage is bloody and mixed with pus, the drainage may be described as ______________ - ____________________.

LEARNING ACTIVITIES - concluded

9. Drainage that is very thick and sticky may be ________________ drainage.

10. How would you describe a dressing that does not show any drainage?

____

NURSING ASSISTANT SKILLS

Module K4 - Use of Binders and Bandages

RATIONALE

In this module, you will learn how to apply binders and bandages correctly making sure your patient is safe and comfortable. Read this module to also learn some of the reasons for applying binders and bandages.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Identify the purposes for using a bandage or a binder.
2. Demonstrate the procedure for applying the:
    a. Ace bandage
    b. Sculte tus Binder
    c. T-Binder
    d. Flexible Abdominal Binder
    e. Sling
    f. Antiembolism Stockings

LEARNING ACTIVITIES

Directions: Read all of the information and answer the questions at the end. Be sure to view the Trainex, Application of Binders and Bandages. You will be asked to demonstrate the five different procedures for applying different binders and bandages. So GET BUSY and learn them. Ask your instructor for help if you need it.

ACTIVITY #1. The Use of Binders and Bandages

Directions: Read this information.

A bandage is a length of material applied in a manner to fit a part of the body, usually an extremity. Bandages are dispensed in rolls of various widths. An example of a bandage is an ace bandage.

LEARNING ACTIVITIES - continued

A binder is a piece of material specifically designed to fit a part of the body. The binder may be designed to fit a large body area as the chest, the abdomen, or the breasts. It may also be designed to fit an extremity. Examples of a binder include:

1. scultetus binder
2. T-binder
3. sling
4. antiembolism stockings

Binders and bandages are used for many purposes, such as:

1. to apply an even, gentle pressure to improve circulation and to prevent or to reduce swelling
2. to immobilize a part of the body
3. to support a weakened body part
4. to hold a dressing or splint in place

A binder or bandage well applied will promote healing, prevent damage to wounds and skin, and offer the patient comfort and security. Below are general principles to remember when applying a binder or a bandage.

1. A bandage or a binder is never used to absorb drainage. Dirty bandages and binders may cause infection if applied over a wound or skin abrasion. Wounds or incisions are first covered with sterile dressings before the clean binders or bandages are applied. If the binder or bandage becomes soiled with drainage, replace it with a fresh one.
2. A bandage or a binder should be applied securely so that it will not move when the patient moves. Friction from a loose bandage or binder may result in chafing and skin abrasions.
3. Before applying a bandage or a binder, clean the area to be covered and dry the area thoroughly.
4. The bandage or binder should be released and rewrapped at least every eight hours. Leave the bandage or binder off for about twenty minutes.
5. The bandage or binder should be wrapped in the direction of the blood flow back to the heart. Start wrapping at the bottom and wrap up.
6. After a bandage or binder has been applied, observe the part frequently for signs of impaired circulation.

LEARNING ACTIVITIES - continued

ACTIVITY #2. Application of Binders and Bandages

Directions: Read the following procedures. When you are ready to demonstrate each procedure, your instructor will check off the steps as you accomplish them and make comments on your performance.

Procedure for the Application of the Ace Bandage

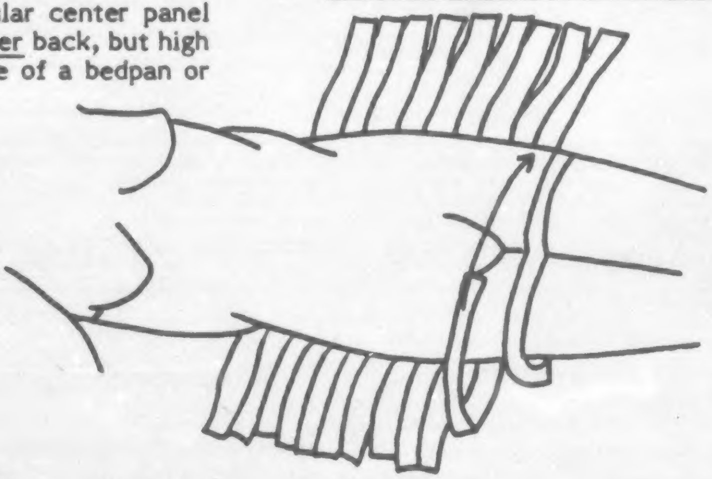
PROCEDURE: APPLICATION OF THE ACE BANDAGE	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment: adhesive tape, ace bandages. Ace bandages are dispensed in 2-inch, 4-inch, and 6-inch wide rolls. You may need the 2-inch ace to wrap the foot and the ankle or the hand and the wrist, the 4-inch to wrap calf or the forearm, and the 6-inch to wrap the thigh. Look at your patient and decide which width of ace you will need and how many of each.	1. ______________________
2. Explain the procedure to your patient and the purpose of the bandage.	2. ______________________
3. Wash and thoroughly dry the area to be wrapped.	3. ______________________
4. Position the patient.	4. ______________________
5. Apply the ace bandage using a circular turn to anchor the bandage, a figure-of-eight turn to wrap joints, and a spiral turn to move up the calf or the forearm. Remember to always wrap towards the heart in the direction of returning blood to prevent impairment of circulation. Be sure the tension of each bandage turn is equal. Do not stretch the bandage to make it fit. Try to avoid unnecessary wrinkles and overlapping of turns.	5. ______________________
6. Leave the toes and the fingers exposed so that signs of circulatory impairment may be observed.	6. ______________________
7. Fasten the bandage securely with tape. Make sure the fastened end is away from all wounds or the inflamed areas.	7. ______________________

LEARNING ACTIVITIES - continued

PROCEDURE: APPLICATION OF THE ACE BANDAGE	DEMONSTRATION/COMMENTS
8. Check the patient's toes or fingers frequently for signs of circulatory impairment. If you notice symptoms of circulatory impairment, remove the ace bandage immediately and elevate the entire leg with pillows. Notify the nurse in charge.	8. ____________________

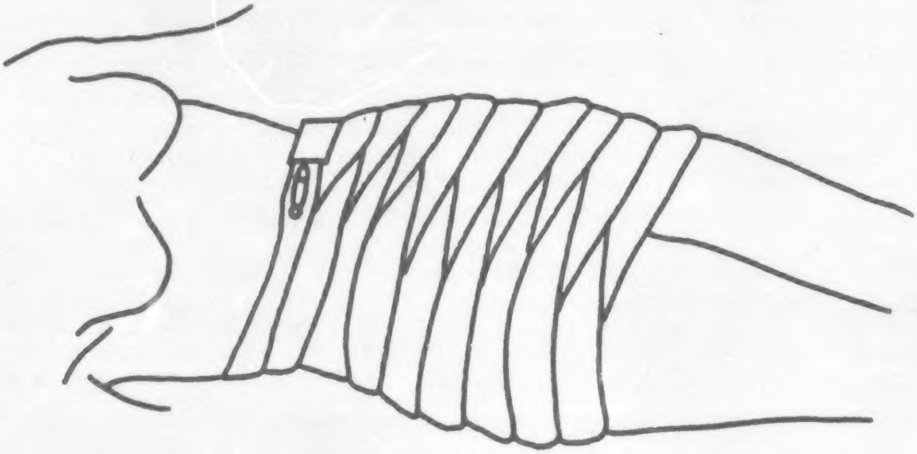
Procedure for the Application of the Scultetus or Many-Tailed Binder

PROCEDURE: APPLICATION OF THE SCULTETUS OR MANY-TAILED BINDER	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment: safety pins, scultetus binder. The scultetus binder usually comes in four sizes: SMALL, MEDIUM, LARGE, and EXTRA LARGE. Determine the size of binder you will need and order it from Central Supply. (Use you own judgment for size.)	1. ____________________
2. Explain the procedure to your patient and the purpose for the binder.	2. ____________________
3. Wash and thoroughly dry the abdominal and the lower back areas that are not covered by the dressing.	3. ____________________
4. Apply the scultetus binder. Remember to position the rectangular center panel against the patient's lower back, but high enough to permit the use of a bedpan or toilet when needed.	4. ____________________



LEARNING ACTIVITIES - continued

PROCEDURE: APPLICATION OF THE SCULTETUS OR MANY-TAILED BINDER	DEMONSTRATION/COMMENTS
5. Overlap the two top tails on a straight line and fasten with safety pins. Remember to slip your fingers under the material so you do not stick the patient with the pin.	5. ____________________



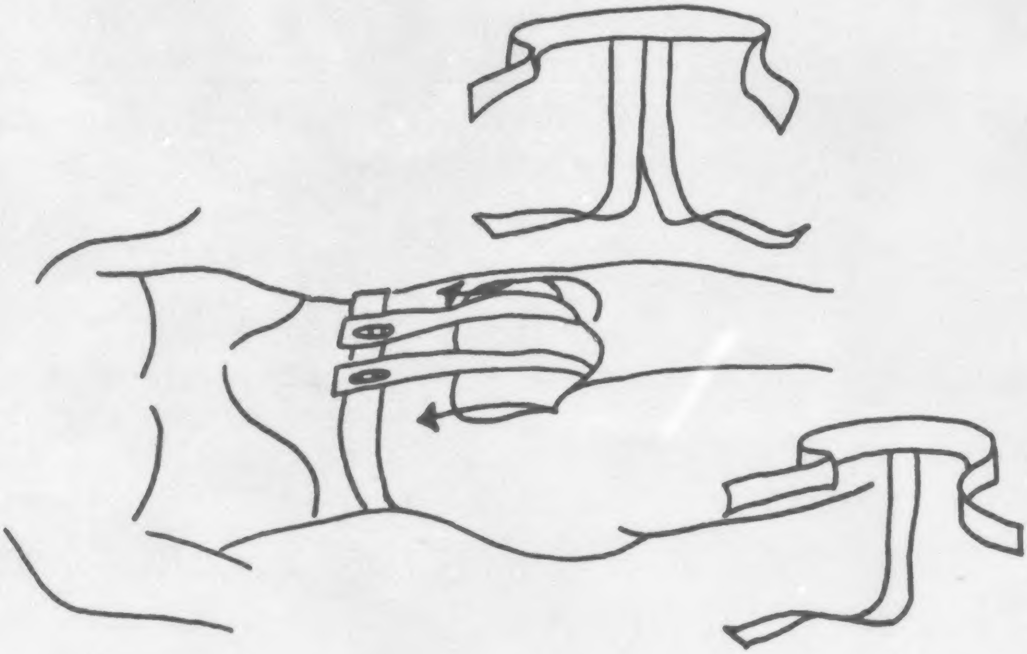
Procedure for the Application of the Single-T or Double-T Binder

PROCEDURE: APPLICATION OF THE SINGLE-T OR DOUBLE-T BINDER	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment: safety pins, single-T or double-T binder. The single-T binder is designed for women patients and the double-T binder is designed for men. A female patient may need a double-T binder if rectal or perineal surgery is extensive and requires a large dressing. T-binders are ordered from Central Supply. They may be made of a disposable material.	1. ____________________
2. Explain the procedure to your patient and the purpose for the binder.	2. ____________________
3. Wash and thoroughly dry the rectal or perineal area that is not covered by a dressing.	3. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: APPLICATION OF THE SINGLE-T OR DOUBLE-T BINDER	DEMONSTRATION/COMMENTS
4. Apply the T-binder.	4. ____________________
5. Fasten the binder with safety pins.	5. ____________________

DOUBLE-T BINDER



SINGLE-T BINDER

Procedure for the Application of the Flexible Abdominal Binder

PROCEDURE: APPLICATION OF THE FLEXIBLE ABDOMINAL BINDER	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment.	1. ____________________
2. Explain the procedure to your patient and the purpose for the binder.	2. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: APPLICATION OF THE FLEXIBLE ABDOMINAL BINDER	DEMONSTRATION/COMMENTS
3. Place the binder under buttocks correctly.	3. ____________________
4. Pull the binder snugly over the abdomen to fasten.	4. ____________________

Procedure for the Application of a Sling

PROCEDURE: APPLICATION OF A SLING	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment: triangular sling.	1. ____________________
2. Explain the procedure to your patient and the purpose for the sling.	2. ____________________
3. Apply the sling. Be sure that the hand is elevated and that the fingers are exposed.	3. ____________________
4. Tie the ends of the sling in a knot at the side of the neck towards the front. Do not tie the knot at the back of the neck.	4. ____________________
5. Check the exposed fingers frequently for signs of circulatory impairment.	5. ____________________

Procedure for the Application of Antiembolism Stockings

PROCEDURE: APPLICATION OF ANTIEMBOLISM STOCKINGS	DEMONSTRATION/COMMENTS
1. Wash your hands and collect equipment: antiembolism stockings. Antiembolism stockings come in two lengths: below-the-knee and upper-thigh length. Check the doctor's orders before you send for the stockings. Antiembolism stockings are fitted so you must measure the patient to order the proper size: a. Below-the-knee length. Measure around the largest portion of the calf; measure the length from the heel to the back of the knee.	1. ____________________

LEARNING ACTIVITIES - continued

PROCEDURE: APPLICATION OF ANTIEMBOLISM STOCKINGS	DEMONSTRATION/COMMENTS
b. Thigh length. Measure around the calf and the thigh; measure the length from the heel to the line at the bottom of the buttocks.	
2. Explain the procedure to your patient and the purpose for applying the stockings.*	2. ____________________
3. Wash and thoroughly dry both legs. The stockings will be easier to apply if a small amount of powder is applied to the legs.	3. ____________________
4. Insert hand into top of stocking and grasp heel pocket. Turn stocking inside out to the pocket.	4. ____________________
5. Stretch stocking open at the heel and fit foot into the heel pocket.	5. ____________________
6. Grasp the top of the stocking and pull over the foot, gathering material at the ankle. Begin fitting and pulling the stocking around the ankle and calf, working up to full length. For below the knee stockings, DO NOT cover any portion of the knee; DO NOT turn down the top of the stocking.	6. ____________________
7. Make sure heel and toe fit snugly. Smooth any excess material.	7. ____________________
8. Check the circulation in the feet through the hole in the bottom of the stocking.	8. ____________________

*Antiembolism stockings are used to increase peripheral circulation and give support to the legs.

LEARNING ACTIVITIES - continued

Exercise 1.

Directions: Observe a demonstration given by your instructor on applying the:

1. Ace bandage
2. Scultetus binder
3. T-binders
4. Sling
5. Antiembolism stockings

Exercise 2.

Directions: Answer these questions by filling in the blanks or by circling TRUE or FALSE. Answers can be found on page 11 of this module.

1. A ____________________ is a length of material applied in a manner to fit the body part.
2. A ____________________ is a piece of material specifically designed to fit a body part.
3. Give an example of a bandage. ____
4. List four examples of a binder.
   a. ____
   b. ____
   c. ____
   d. ____
5. An ace bandage is sometimes used to immobilize a joint. TRUE FALSE
6. A scultetus binder may be used to provide support to weakened abdominal muscles. TRUE FALSE
7. Ace bandages are often used to absorb drainage when applied to the legs after surgery. TRUE FALSE
8. A T-binder may be applied to hold rectal or perineal dressings in place. TRUE FALSE
9. The single T-binder fits best on the male patient. TRUE FALSE
10. The binder or bandage should be released and rewrapped at least every ____________ and should be left off about ________________ minutes.

LEARNING ACTIVITIES - concluded

11. List six signs of impaired circulation.

    a. ______________________________

    b. ______________________________

    c. ______________________________

    d. ______________________________

    e. ______________________________

    f. ______________________________

Exercise 3.

Directions: Now, choose another student to be your patient. Take the checklist provided in your module to your instructor and demonstrate the procedure for applying the: ACE BANDAGE, SCULTETUS BINDER, T-BINDER, SLING, and ANTIEMBOLISM STOCKINGS.

ANSWERS

ACTIVITY #2

Exercise 2

1. bandage
2. binder
3. ace
4. scultetus, T-binder, straight abdominal binder, antiembolism stockings, sling
5. TRUE
6. TRUE
7. FALSE
8. TRUE
9. FALSE
10. 8 hours, 20
11. a. swelling
    b. unusual skin color
    c. toes or fingers unusually cold
    d. inability to move fingers or toes
    e. complaints of numbness, burning, or tingling pain
    f. slow capillary refill

NURSING ASSISTANT SKILLS

Module K5 - Care of the Patient with Tubes Connected to Gravity or Suction

RATIONALE

There are many types of tubes used to drain the body of fluids. You will feel more comfortable and be better prepared to safely care for a patient with a tube if you understand your responsibilities in caring for the patient and the purpose for the tube.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Verbally identify your responsibilities in caring for a patient with drainage tubes.
2. Identify the most commonly used tubes and their purposes.
3. View an instructor's demonstration and display.

LEARNING ACTIVITIES

Directions: This is the last part of Module K. All of the information you will need to complete this section is included. Read the information and answer the questions. If you need help, get it from your instructor.

ACTIVITY #1. Care of the Patient with Tubes Connected to Gravity or Suction

Directions: Read this material.

Fluids are removed from the patient's body through tubes connected either to gravity drainage or suction. When fluids are removed by gravity, the collecting bottle is placed nearest to the patient at a level lower than his body. If the tube is to drain by suction, it will be connected to a suction machine, usually either a Gomco, Wangenstein, or Sump.

Many of the tubes used are named according to the location in the patient's body, for example: A nasogastric tube is inserted through the patient's nose and into the stomach; a gastrostomy tube is positioned directly into the patient's stomach through an incision in the abdominal wall; a nephrostomy tube is inserted directly into the patient's kidney through an incision; and a cecostomy tube is inserted into the patient's cecum.

Your responsibilities in caring for patients with drainage tubes are:

1. Make sure the tube is draining. Check the tubing as it leaves the patient's body to make sure the fluid is moving in the tubing. Watch the level of the fluid in the collecting container. Report immediately to the nurse in charge if the level in the container stops rising or if there is a sudden rapid increase in the amount.

LEARNING ACTIVITIES - continued

2. Note the color and the consistency of the fluid being drained. Report to the nurse in charge if there is a sudden change in the color of the drainage.

3. Empty the collecting container and accurately measure the amount of fluid drained. Report the amount to the nurse in charge.

ACTIVITY #2. Drainage Tubes

Directions: Read this material.

Some of the most commonly used drainage tubes that you will be responsible for include:

1. The nasogastric or the gastrostomy tube: The nasogastric and the gastrostomy tubes are connected to suction and are used to keep the stomach and the duodenum free of gas and gastric secretions. While these tubes are in place, your patient will probably be NPO. The throat will be dry and irritated. Some doctors may allow the patient ice chips or sips of water but these should be taken sparingly. Give your patient frequent mouth care. He may be allowed to rinse the mouth out and gargle as long as he does not swallow the water. If the patient has a nasogastric tube, he will also require regular cleansing of the nose to keep the mucus membranes in good condition. Apply a small amount of lubricant in the nose around the tube. Brushing the teeth should also be a part of good mouth care.

2. The T-tube: The T-tube is a gravity drainage tube that is often used following a cholecystectomy or surgical removal of the gallbladder. It is called a T-tube because it is shaped like the letter "T" and is designed to fit into the common bile duct to drain the bile produced by the liver. The bile drains into a bottle placed on the floor or into a bile bag which can be attached to the patient's leg when he is up walking around. Remember to be careful not to raise the collecting bottle above the level of the patient since the contents would then flow back into the area of the surgery. However, the physician may order that the bottle be gradually raised for a period of time before tubes are removed from the patient.

3. The Hemovac: The Hemovac is a tube which is connected to its own vacuum suction apparatus. It is designed to drain blood and fluid that accumulate in the area of the surgery postoperatively. You may be asked to "milk" the tubing at frequent intervals to make sure that no clots block the drainage. You may also need to "reactivate" the hemovac at periodic intervals. To reactivate, you open the plug to the suction apparatus and push the air out before plugging it back up.

4. The penrose drain: The penrose drain is a soft, flat drainage tubing which is inserted into the area of the surgery to drain any fluid that may accumulate. It is not connected to any drainage bottle but is left open and is surrounded by many sterile dressings. When there is a penrose drain in the area of the incision, you must carefully and frequently observe the dressing for drainage. The dressing may need to be changed or reinforced frequently. The physician may decide to remove a penrose drain slowly - a little at a time each day - so that the tissues behind the drain will have a chance to heal. Gradual removal of the drain is known as "advancing" the penrose drain.

LEARNING ACTIVITIES - concluded

Exercise 1.

Directions: Ask your instructor to display the nasogastric tube, the T-tube, the Hemovac, and the penrose drain. Watch a demonstration of "milking" the hemovac tubing and reactivating the hemovac.

Exercise 2.

Directions: Answer the following questions by filling in the blanks or by circling "TRUE" or "FALSE". Answers can be found in the preceding information.

1. Fluids are removed from the patient's body through tubes connected either to ______________ drainage or ______________.

2. Name two types of suction machines that a tube may be connected to.

   a. ______________________________

   b. ______________________________

3. A ______________ tube drains the stomach through an incision in the abdominal wall.

4. A nephrostomy tube drains the ______________.

5. No drainage in the collecting bottle means that there was nothing to drain and it need not be reported to the nurse. TRUE FALSE

6. Any sudden increase in drainage in the collecting bottle should be reported to the nurse immediately. TRUE FALSE

7. The color of drainage changes frequently and any change does not necessarily need to be reported. TRUE FALSE

8. If your patient has a nasogastric tube, what two areas need your special attention?

   a. ______________________________

   b. ______________________________

9. A T-tube is shaped like the letter "T" and is designed to drain ______________ after the gallbladder is removed.

10. Pushing the air out of a Hemovac is known as "___________" the Hemovac.

11. The ______________ drain is a soft, flat tubing inserted into the area of surgery to drain any fluid that may accumulate.

12. When the physician gradually removes a penrose drain, he is "__________" the drain.

NURSING ASSISTANT SKILLS

Module K6 - Cultural Awareness for Preoperative and Postoperative Care

RATIONALE

Do you have a certain home remedy for a cold? Do you prepare special foods and perform special rituals according to your ethnic background for holidays such as Christmas? If you do, we say you are relating to your cultural background. Culture is defined as the ideas, beliefs, practices, and skills of a certain people over a certain period of time. Culture is constantly changing as we are exposed to different peoples and different environments. We, as health workers, are concerned with giving the best possible care to our patients. In order to do this, we need to be aware of the differences in ideas, beliefs, practices, and language of other cultures. We need to know what our patients know about their illness. This is an introduction to cultural differences that can affect our preoperative and postoperative care to our patients in southwestern Arizona.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Recognize behavior and other physiological responses related to cultural differences in the perception of pain and disease that might affect preoperative and postoperative care.
2. Recognize communication blocks and language barriers found in other cultures.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this module is included. Read all of the material and be prepared to work with patients from various cultures in the health care facility.

ACTIVITY #1. Preoperative and Postoperative Care of Various Cultures

Directions: Read the following information.

Mexican-American Influence

The Mexican-Americans in our area use the term "enfermadad" for illness. They believe that much illness comes from how they live their lives. Factors that can cause illness include fatigue, disregarding hygienic rules, environmental changes, and germs. The symptom of a disease is very important. The symptom is a cue for the kind of treatment and the type of curer that will be consulted. Symptoms may include fatigue, weakness, incapacity to perform duties, dizziness, general fever and local fever, pain, nausea, gripping, mucous and cough, changes in skin color, and rashes. Pain is referred to as "dolar" but the Mexican language has many terms to describe specific kinds of pain. If an interpreter is available, the pain will be described more accurately.

LEARNING ACTIVITIES - continued

Understanding how a Mexican-American believes illness is transmitted can help us understand the behavior as we care for him. Examples of transmission of illness beliefs are now given. Dirty water carries illness. If the wind passes over a dead thing and then blows on someone, illness may occur. Dirt and dust carry germs that move in the air. The ingestion of wrong foods such as too hot or too cold foods can cause illness. Changing the temperature of the environment that the body is accustomed to can be dangerous. By sitting on a cold bench a person can catch a cold. By sitting on something too hot, a person can develop "piles" (hemorrhoids). Standing or lying in a draft can cause illness. Sudden chilling by bathing should be avoided during the presence of a fever or the menstrual period. If a person drastically changes his life-style, illness may occur. Some processes are considered natural phenomena which provide for getting rid of "dirt". Examples are vomiting, diarrhea, drainage of a sore, and eruption of a rash. These processes are considered good.

The kind of symptom determines the type of curer the Mexican-American will consult. Many home remedies or over the counter drugs may be used first. The sobador (sobadora) is a massager who prescribes various therapies. The curandero (curandera) has been given the gift of healing from God and is most competent in the use of herbs, massages, rituals, and prayers. His position becomes greater when the medical doctor is not curing the illness or when Mal ojo-evileye has put a curse on the person. There are certain disorders that are called "Mexican diseases" such as "empacho" (indigestion) and cannot be treated by an Anglo doctor.

Mexican-Americans can have an extended nuclear family which excludes a vast support system. A woman achieves social status through marriage so is encouraged to marry early. The eldest male in the family is the figure of authority with one exception. In matters of health the female's knowledge is the authority. A woman's role is one in which she is expected to respect and obey her husband. A man may hesitate to seek medical care as being sick degrades his male role. Often he is the only breadwinner of the family and cannot afford to miss work.

We have introduced you to the Mexican-American culture. Perhaps through your experiences you could enrich this introduction.

Indian Influence

Indians classify illness into two categories:

1. Illness of an ordinary nature that occurs in old age such as accidents. Acceptable situations such as exposure to extremes in heat and cold or objects that can harm the body are accepted as part of life and treated.

2. Illness that cannot be explained fits into the mysterious nature caused by super natural powers and are dealt with on a super natural level.

The curers in the Indian culture are Medicine men and Medicine women. They can diagnose the cause of illness and prescribe the cure. There are many different types of medicine men/women who perform specific rites for specific illnesses. The Apache, Navajo, Pima, Papago, Hopi, Yuma, Yaqui all have a Medicine man (a curer), male or female.

LEARNING ACTIVITIES - continued

The Papago and Yaqui Indians have the greatest population in our immediate area, therefore, we will present aspects from their respective cultures.

Papago

Papagos are greatly concerned with what causes illness. Illness comes from offending one of the many supernatural forces. Unless the force or "Being" is appeased, the illness will become more severe. Wild and domesticated animals, plants, and the natural elements are examples of beings and must be treated with respect. Ghosts from the dead are still believed to bring illness. The ghosts may return in the form of animals that have supernatural powers to send illness. Thinking evil thoughts can bring illness. The Papagos place a great emphasis on peacful living and in avoiding quarrels. Proper respect to the Medicine man and ceremonies are a safeguard against illness. Disrespect here can bring illness.

Illness is defined by the symptoms, not the diagnoses. If there are no symptoms, there is no illness. The emphasis is placed on treating the ill person, not just the symptoms the person presents. When a Papago gets sick, he may go to a Medicine man called the "Makai" to find out the cause of the illness and the prescribed cure. The "Makai" performs rituals, diagnoses the illness, and then recommends the "singers" to perform the actual cure. The Medicine man is considered a soul doctor who gives peace and emotional support along with the skills of healing. This permits the ill person to remain at home in familiar surroundings with support from family and friends. An "Indian sickness" is a type of illness that will respond only to Indian beliefs and folk medicine. A sudden, acute illness might be called a "white man's sickness" and a doctor would be consulted.

The Papago people are organized into patriarchal family groups. Women will ask the male head of the household for permission to do what is needed. Occasionally, a father is not in the household and a woman will take over. Grandparents play an important role in the household especially in the area of children. Often, a child may be given to and raised by the grandparents.

Yaqui

The Yaqui culture is a blending of Indian, Mexican and Anglo backgrounds.

Yaqui's believe that illness comes from natural causes. Overexertion is the cause of illnesses, such as pain in the chest, pain in other parts of the body, and weakness. Overexposure to the sun can cause weakness, faintness, headaches, blindness, and rashes. Alternate exposure to heat and cold can cause fever, headache, and earaches. Mechanical injuries, sprains, broken bones, burns, and cuts, can be caused by accidents or by supernatural means, such as witchcraft. Dirt can cause illness. Dust can get into a peron's throat and cause illness. The same concept is applied to a "dirty stomach". Germs are thought of as little things in dirt that can make you sick. Strong feelings such as rage, fright, and jealousy can cause weakness, diarrhea, fever, and convulsions. Sin may be punishable by God sending an illness. Witchcraft gives individuals or creatures evil powers that can send sickness. Yaqui's believe that a lunar eclipse can cause deformities in unborn children. Also, animals and plants in the wilderness may be endowed with powers.

LEARNING ACTIVITIES - continued

Treatment of an illness can be one or a combination of the following: "seataka", prayer, medicine, massage, and diet. "Seataka" is a special power that can cure illness or give the endowed person an extraordinary sensitivity and desire to help others. The "hitevi" is the Yaqui professional curer and is paid for his services. The "hitevi" diagnoses the illness and recommends the treatment.

Black Influence

Some of the blacks in our area believe the origin of an illness is either natural or supernatural. A natural illness arises from the individual's failure to observe the laws of nature. An unnatural illness arises from one's response to the society in which one lives. Illness is often referred to as "misery".

The ingestion of food, home medicine to prevent or to cure illness, and the excretion of wastes are important in maintaining good health. Failure to do this renders the individual susceptible to attack from outside forces. Certain periods of life are more vulnerable; infancy, pregnancy, postpartum period, and old age. Moderation in life-style is important.

Some Blacks believe that man is a part of nature and is influenced by the laws of nature. The changing seasons, the position of the planets, the cycle of the moon, the plants, and animals can affect man. An almanac of the "signs" may be used as a guideline for medical purposes as well as selections for the proper time to plant a garden. The time of elective surgery may be chosen according to the "signs".

The condition of the blood is considered important. Cold air, dampness, and impurities enter the body through the skin into the bloodstream. Illness is related to the state of the blood and circulation. For example, cold air enters through the pores of the skin into the bloodstream and then settles in the joints causing arthritis. Many medicines taken to maintain health are laxatives. This preoccupation with laxatives reflects the idea that the body needs to be cleansed of its impurities.

Religion plays an important role for many Blacks. Belief in Jesus as a warm, caring person, in God as a stern Father and the teachings of the Bible are the basis of religious beliefs. Sin can result in illness and prayer will cure the illness. Closely interwoven with religious beliefs and practices are the leftovers of voodoo and witchcraft beliefs. Spiritual healers have the power to cure as a gift from God. Laying on of hands, prayer, home remedies such as herbs, over the counter medicines, baths, soaks, poultices, and liniments are used to cure illness. Folk practioners may also be consulted.

The most important social ties are those of kinship (no matter what state the relationship might be in). The church membership and neighborhood ties are next in importance. The eldest female in the household often takes on the role of authority as the male figures may move in and out of the household.

LEARNING ACTIVITIES - continued

ACTIVITY #2. Communication, Language, Pain: Cultural Influences

Directions: Read the following.

Communication is the exchange of information between people. Communication can be verbal, the spoken word, or non-verbal such as a facial expression, a gesture or body position. Communication patterns vary from culture to culture. They can be formal; by way of newspapers, radio, TV, telephone and postal services. They can be informal; by way of meetings, family get-togethers, and neighborhood gossip.

The quality of patient-staff communication directly affects patient care. Barriers resulting from differences in cultural beliefs and values, differences in social and economic status, education, sex, and age, affect the communication process. Communication has to be kept in terms and at levels the patient can understand. Written communication is effective only if the patient is literate. If the patient is illiterate, other means of communication are necessary. Cultures have various patterns in communication which must be recognized for effective communication. How you say hello or good-bye may affect the rapport with a patient. Certain formalities of "chitchat" may be necessary before serious discussion may take place. The speed of a conversation may create misunderstanding. A Navajo Indian may consider it polite to pause and reflect on the conversation before responding. In order not to offend a patient from another culture, an awareness of taboo subjects is necessary. Confidentiality means different things to different people. Attitudes toward confidentiality need to be considered. Developing an awareness of how various cultures display emotions such as love, anger, and frustration need to be recognized for effective communication. Accepting silence instead of reacting to silence will be met with respect from some cultures. Direct eye contact is expected in the American culture. The Papago Indian culture believes eye contact is a discourteous form of staring and eye contact should be avoided.

Language differences can create many problems for the patient and the staff. Patients may be embarrassed about their inability to understand English and may say they understand explanations and directions to cover up their inadequacies. In times of stress, patients may regress to their own language where they are more comfortable. The vocabulary of a language reflects the individual culture and often words are not interchangeable from one culture to another.

Using an interpreter is a vital link in patient care. However, using an interpreter has its advantages and disadvantages. Accurate communication is a necessity. An interpreter may alter information because of inadequate skills in the langauge or because of prejudices. The patient-staff relationship may be hindered by the presence of a third person. Attention to treating the patient as a unique person is essential for effective communication.

Pain

Recognizing cultural beliefs and perception of disease will help in evaluating a patient's reaction to pain. The complex cultural attitude will affect the patient's response to pain. The pain threshold may vary according to the emotional and physiological needs of the patient. The role that illness plays in the patient's life will in turn affect the response to pain.

LEARNING ACTIVITIES - concluded

Summary

We have discussed some generalized and specific views from a few cultures. Hopefully, this will introduce you to the uniqueness of each patient and will encourage you to learn more about them and their cultural backgrounds. If you are an Anglo, perhaps you could examine your perception of illness and how your culture affects your beliefs and attitudes.

The most important thing to be aware of is that there are differences among people and everyone's beliefs and feelings should be respected no matter how unusual they may seem to you.

The objectives of this module will be met by taking care of people from different cultures in the clinical area and then discussing this situation in the classroom with other students. Be sensitive and be aware.

Sources of Information

Materials for this module were taken from the following texts. If you are unable to locate these materials and desire some additional information, ask your instructor to assist you.

Texts

1. Afek, Louella and Spence, Allgn. Cultural Components-A Manual for Nurses. University of Arizona College of Nursing, Tucson, AZ.

2. Brownlee, Ann Templeton, Ph.D. Community Culture, and Care. St. Louis: C.V. Mosby Co., 1978.

3. Kay, Margarita Artschwager. Health and Illness in the Barrio Women's Point of View. University of Arizona, Tucson, AZ, 1972.

4. Shaw, Daniel R. Health Concepts and Attitudes of the Papago Indians. University of Arizona, Tucson, AZ.

5. Shutler, Mary Elizabeth. "Disease and Curing in a Yaqui Community." Ethnic Medicine in the Southwest, ed. Edward H. Spicer. Tucson: University Press, 1977.

6. Snow, Loudell Marie Fromme. "The Medical System of a Group of Blacks." Ethnic Medicine in the Southwest, ed. Edward H. Spicer. Tucson: University Press, 1977.

NURSING ASSISTANT SKILLS

Module L - Care of the Dying Patient

RATIONALE

Not all patients who enter a health care facility can be cured. Some patients die. Death is sometimes sudden and unexpected, but usually is not. You will have the responsibility of caring for the patient who is dying and for the patient's family.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Respond verbally to your own feelings about death.
2. Identify the five stages of death acceptance.
3. Recognize signs of approaching death.
4. Demonstrate the procedure for giving postmortem care.

LEARNING ACTIVITIES

Directions: All of the information you will need to complete this module is included in this module and in a Trainex filmstrip. Be sure to view the Trainex. If you need any help or have any questions, ask your instructor to help you.

ACTIVITY #1. Understanding Feelings of the Dying Patient

Directions: View side #1 of the Trainex, Care of the Dying Patient. Then read the following information.

We often think of death as a strange, new experience. Some patients you care for will experience death. Most people now die in hospitals or in nursing homes rather than at home. Families may be scattered across the country and the young may have never known grandparents or older aunts and uncles. Your experience in nursing may be the first time you have come in contact with death.

As a member of the nursing team, you should be dedicated to good health and preservation of life. You may view the dying patient as a personal failure. You may deny that your patient is dying and find yourself constantly trying to reassure her with "everything will be all right". You may completely avoid your patient and feel angry or frustrated when she demands your attention. You may feel compelled to help her seek some miraculous cure you have heard about. To give the best of care to your patient, you must first understand your own feelings about death.

LEARNING ACTIVITIES - continued

Exercise.

Directions: The following role-playing exercise will help you surface your feelings about death. Hopefully, this exercise will also help you understand how a dying patient may feel about death. Do the exercise with a friend or small group and your instructor.

SITUATION: Try to imagine that you are dying. You did not believe it when your doctor told you, but you knew that something was very wrong on your first appointment. Your own doctor had another doctor examine you to confirm the diagnosis. You are beginning to feel a little weaker every day.

Respond to these situations concerning dying.

1. Describe how you feel about dying.
2. What would you like to do now more than anything else?
3. What are some of the things that worry you most? Is there anything you can do about some of those things? Can anyone help you?
4. How do you want to be treated by others?

ACTIVITY #2. Five Stages of Death Acceptance

Directions: Read this information.

You will be better prepared to help the dying patient if you understand some of the emotional reactions of the patient toward death. Although people face death in many different ways, studies done by the psychiatrist, Elisabeth Kubler-Ross, have shown that patients pass through five stages as they die. Some patients may spend a little longer in one stage than in another. Some patients get stuck in one stage and never move to the next. Family members and close friends of the dying patient are also going through these same stages but may be at a different stage than the patient.

The stages leading toward acceptance of death include:

1. Denial and Isolation: When first facing death, the patient will respond with "No, not me!" Denial helps soften the blow for awhile and gives the patient hope. He may ask you many questions or want to see the x-ray or blood reports. Do not ignore him. Answer the questions that you can and tell him you will find the nurse or the doctor to talk with him.
2. Anger: Denial gives way to feelings of anger, resentment, helplessness. "Why me?" During this stage, the patient may be very difficult to care for as nothing you do may please him. He may complain constantly and make what appears to be unreasonable requests. Do not take these expressions of anger personally, but try to meet the demands. Visit him before he calls you. Do not avoid him. By allowing him to express these feelings of anger and resentment, he will move more rapidly into the next stage.

LEARNING ACTIVITIES - continued

3. Bargaining: As the patient continues to try to cope with the inevitable death, she may attempt to negotiate a trade. The deal may be with God. For example, "If I promise to teach Sunday School maybe God will let me live another year." Or it may be with the physician or nurse, "If you just let me watch my daughter graduate from college, I will be ready to go." When possible, the patient's request should be granted.

4. Depression: During this stage, the inevitable is apparent to the patient and she can no longer deny the coming death. Allow the patient to talk and to cry. Listen and do not give false hopes. You do not need to say anything, just be there, available when needed. The patient may request the minister, priest, or rabbi. Report such requests to the nurse in charge.

5. Acceptance: In this stage, the patient is neither angry nor depressed. This is not a happy stage but is a stage where she feels at peace and is content. The patient may wish to talk about past experiences -- the good times and the mistakes. She may want to be alone with her thoughts and may speak only occasionally with visitors. Family members may feel rejected. This is usually a productive stage. The patient is now ready to plan for death. She can make arrangements for the family and settle business matters. The family may not be ready for this stage and will need your help and understanding.[1]

[1] Kubler-Ross, Elisabeth, On Death and Dying, McMillan Publishing Company, Inc., New York, New York, 1969.

ACTIVITY #3. Signs of Approaching Death

Directions: View side #2 of the Trainex, Care of the Dying Patient. After you have viewed the filmstrip, read this information.

Death comes to different patients in many different ways. The patient may have a period where she feels better and seems to be recovering, then, suddenly, she dies. Some patients may tell you the day that they will die. Sometimes death comes after a long time of gradual loss of strength and body functions. When death is eminent, there are signs and symptoms that you will observe. Some signs of approaching death are listed below.

1. Cyanosis or dusky skin; the face may be pale due to a decrease in the blood pressure and the slowing down of the circulation. A point to remember, which may help comfort a family member, is that because the blood flow to the brain is diminished, the patient close to death very seldom feels any great pain.

2. If still conscious, the patient may complain of feeling cold; hands and feet may be cool to touch because of the decreased circulation.

3. The patient may have an elevated temperature. She may be profusely diaphoretic even when cool to the touch.

4. Eyes may stare into space with a fixed expression. Pupils may not react or may react very slowly to light.

5. Incontinence of urine and stool from the loss of muscle tone may occur.

LEARNING ACTIVITIES - continued

6. Jaws may drop open and the patient may have difficulty swallowing.

7. Respirations become slower and more labored. The patient may even experience Cheyne-Stokes respirations in which the respirations become rapid and deep and then suddenly stop entirely for a few seconds. Respirations may sound very congested.

8. Pulse is rapid, weak, and irregular. As the patient dies, the respirations will stop and the pulse will feel very faint or fluttery. You may be unable to feel a pulse. The pupils will be dilated and fixed and will not respond to light. Notify the nurse in charge and then return to the bedside. You will be needed to help support and comfort the family.

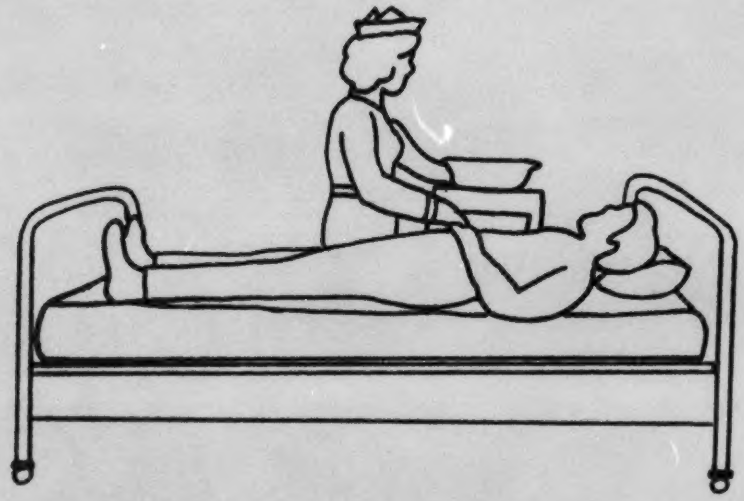
ACTIVITY #4. Postmortem Care

Directions: Read the following procedure. When you demonstrate the procedure in the clinical area, your instructor will check off the steps as you accomplish them.

After the patient has been pronounced dead by the physician, you will be responsible for giving postmortem care. The prefix "post" means after, and "mortem" means death; thus, after death. Postmortem care is the care given the patient after death. The purposes for giving this care are to:

1. Preserve a natural-looking position before rigor mortis sets in. Rigor mortis is the stiffness of the body and limbs which occurs after death.

2. Prepare the body for the mortician or the coroner. A mortician is also called an undertaker. It is the responsibility of the mortician to prepare the body for the funeral. A coroner is an official who investigates the death of those who die from unknown causes or from violent causes or circumstances. Such an investigation always includes an autopsy, which is the examination of the patient's organs to determine the cause of death.



LEARNING ACTIVITIES - continued

Procedure for Giving Postmortem Care

PROCEDURE: GIVING POSTMORTEM CARE	DEMONSTRATION/COMMENTS
1. Lower the bed so that both the head and the knees are flat. Remove all pillows except the one under the head. Straighten the body so that it is in good alignment. The patient's arms may be positioned straight at the sides or over the body at the waist.	1. ____________________
2. Discontinue all treatments and remove all tubing including nasogastric tube, I.V., Foley catheter, tubes or drains in surgical incisions, and oxygen. The nurse in charge will probably do this.	2. ____________________
3. If the patient wears dentures, put them in the mouth. Close the mouth by putting your hand under the chin and by applying upward pressure. You may need to roll a towel under the chin or tie gauze under the chin and over the top of the head to keep the mouth closed.	3. ____________________
4. Close the eyes but avoid touching the eyelid. Hold the lashes to pull the eyelid down over the eye.	4. ____________________
5. Comb the hair and wash the face and neck. Clean up any discharges or secretions including incontinent urine or stool. Replace soiled dressings. Change the gown. Change the sheets if necessary. Treat the patient's body with the respect and gentleness you would if the patient were alive.	5. ____________________
6. Remove all jewelry except wedding rings. Tape rings on with tape or band-aids. Give jewelry to the family.	6. ____________________
7. Check to be sure the patient has an identification bracelet on the wrist and that the name and hospital number are the same as that which appears on the chart.	7. ____________________

LEARNING ACTIVITIES - continued

Exercise.

Directions: Answer the following questions by filling in the blanks or by circling "TRUE" or "FALSE". Answers can be found in the preceding information.

1. A patient is told that the x-ray revealed terminal cancer of the lung. She tells you that she is sure the x-ray reports were mixed up. Which stage of dying is this? ______________________

2. Your patient with terminal heart disease is constantly ringing the call light and demanding one thing after another. Whatever you do for her is wrong or not enough. Which stage of dying does this behavior usually indicate? ___________ ______________

3. What can you do to help this patient move on to the next stage? ___________ ____________________

4. You are caring for a two-year old boy who is dying of leukemia. The mother constantly questions you, "My son is so young; why does he have to die?" "He has always been a good boy; I cannot understand why he should go." In which stage of acceptance of death is your patient's mother? ______________________

5. Your patient calls you to the room constantly. When you answer the call light, he only crys and says over and over,"I know I am dying" or "Please don't leave me." Which stage of acceptance of death is this patient experiencing? ______________________________

6. When a depressed, dying patient tells you he feels weaker every day and can feel himself slowly dying, you should try to cheer him up by telling him he will feel stronger as soon as the medication starts to have an effect.
   TRUE FALSE

7. A patient who wants to plan the funeral should be allowed to do so.
   TRUE FALSE

8. There are five stages of acceptance of death. List them.
   a. ____
   b. ____
   c. ____
   d. ____
   e. ____

LEARNING ACTIVITIES - concluded

9. List five signs of approaching death.

   a. ______________________________

   b. ______________________________

   c. ______________________________

   d. ______________________________

   e. ______________________________

10. Respirations that are rapid and deep and then suddenly stop are known as ____________-______________ respirations.

11. Pupils that do not react to light may be called ______________.

12. Define the following words.

    rigor mortis: ______________________________

    autopsy: ______________________________

    postmortem: ______________________________

13. The official who investigates violent deaths is a/an ________________.

14. You should not try to put dentures in the mouth of a patient who has died.
    TRUE FALSE

15. Patients who have died are frequently incontinent of urine and stool and need to be cleaned before being transferred to the morgue.
    TRUE FALSE

unit 8

NURSING ASSISTANT SKILLS

Module M1 - Admission

RATIONALE

On the following pages you will learn how to meet the needs of the patient on arrival at the health care facility. This packet will describe what you will do, and what you should look for when admitting a patient to your unit. REMEMBER, while you are going through this module, you will become familiar with the many terms used in the health care facility.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Complete an Admission or Assessment Form.
2. Demonstrate admitting a patient by participating in a group discussion.
3. Define admittance vocabulary.
4. Familiarize yourself with admission and assessment forms.

LEARNING ACTIVITIES

ACTIVITY #1. Guidelines for Completing Assessment and/or Admission Forms

Directions: Read the following information.

1. Complete ALL of the requested information.

   In most situations, the nursing aide will record or complete the following information on the appropriate forms:

   a. vital signs
   b. time of admission
   c. height, weight
   d. how admitted/means of arrival, and from where
   e. personal belongings list
   f. orientation to unit

LEARNING ACTIVITIES - continued

2. The practical nurse or the staff nurse will complete the rest of the assessment or admission form.

   Key points to observe in completing the assessment form:

   a. general condition (alert, drowsy, emaciated or thin, etc.)

   b. condition of skin (dry, bruised, cut, etc.)

   c. difficulty in breathing (dyspnea)

   d. coughing - what kind (dry, wet, hacking, productive - amount, color, odor, etc.)

   e. breath (odor)

   f. level of consciousness (alert, comatose)

   g. pain (location and type)

   h. speech (fluent, articulate, incoherent)

   i. complaints ("I have a headache")

   j. ability to move easily

   k. ability to hear (deafness)

   l. ability to see (blindness)

   m. prosthesis (glass eye, artificial limb)

Exercise.

Directions: In a group meeting with your instructor and other students, discuss the following questions concerning admissions. Then write your answers in the spaces provided.

1. What is the first thing you would do when you hear that a new patient is being admitted to one of your assigned rooms?

   ____

   ____

2. What observations should you make of the patient?

   ____

   ____

   ____

LEARNING ACTIVITIES - continued

3. What would you do with the patient's clothes? ______________________________

____

4. When admitting a patient,

   a. what would you say about the surroundings? ______________________________

   ____

   b. where would you put the patient's valuable belongings? ______________________________

   ____

   ____

5. Where would you make a note of your observations and the information given you by the patient?

____

____

____

ACTIVITY #2. Vocabulary Words for Admission of a Patient

Directions: Together with your instructor and your classmates, discuss the following list of words. Then write the definitions in the spaces provided.

1. Admission ______________________________
2. Discharge ______________________________
3. Transfer ______________________________
4. Dentures ______________________________
5. Personal Belongings ______________________________
6. I.D. or Indentaband ______________________________
7. Clothes List ______________________________
8. Vital Signs ______________________________
9. Allergies ______________________________
10. Valuables Envelope ______________________________

LEARNING ACTIVITIES - continued

11. Weight ______________________________

a. actual ____________________ (wt. A or V)

b. verbal ____________________

12. Social Services ______________________________

ACTIVITY #3. Hospital Forms

Directions: On the following pages of this module, you will find five (5) examples of hospital admission forms. The forms shown are teaching samples only. They are similar to forms used in most hospitals. However, the appearance of the forms, and the information requested, will vary according to the facility in which you are employed. Basically, they will be the same as these examples.

Example 1	Nursing Assessment Form - must be completed on both sides.
Example 2	Nursing Assessment Form - another type of admissions form; must be completed on both sides.
Example 3	Nurse's Assessment Form - a third example of an admissions form. One side only.
Example 4	Patient's Personal Belongings Sheet - a continuing record of disposition of patient's belongings from admission, through transfer (if any) to discharge.
Example 5	Discharge Planning Questionnaire - a form used by Social Services in making plans for and/or arranging for discharge of a patient.

Exercise.

Directions: Study the forms and familiarize yourself with them so you will know what to do when asked to complete an admission to your facility or a demonstration in your laboratory.

EXAMPLE 1—*Teaching Sample Only*

Ramirez, Mary T.
Rm 220-3
Dr. Johnson Feb. 15, 1981

NURSING ASSESSMENT FORM

Time of admission 0950 **How arrived?** CART **Accompanied by:** John NURSE

TPR & BP 103°-122-20 - 116/90 **Ht. (A or V)** 5' 7½" (V) **Wt. (A or V)** 134 lbs (V)

Orientation of Patient: **Bed & Side Rails** ✓ **Identaband** ON

Bell Cord ✓ **Valuables to Safe** NONE

In your initial assessment of the patient, please include the following observations:

1. **Chief Complaint** (i.e., Patient's reason for admission and present condition)

PT. STATES Throat has been "scratchy" last 3 days. Difficulty swallowing since yesterday. Generally "achy" all over, especially tender (RT) calf. (She forgot to mention this to DR. Johnson.)

2. **Level of Consciousness** (i.e., incoherent, alert, unresponsive, confused, disoriented, etc.)

Alert, oriented and very cooperative

3. **Skin, Nails, and Extremities** (i.e., Skin turger, color, temperature, diaphoretic, dry, cold, warm, tingling, cramping and calf tenderness, etc.)

SKIN HOT And DRY, mucous membranes pink and moist; nailbeds pale, tenderness in (RT.) calf c̄ tingling in (RT.) foot. (RT) calf warmer than (LT.) to touch.

4. **Emotional State** (i.e., Apprehensive, withdrawn, relaxed, etc.)

Facial expression tense - fists clenched.

5. **Chest—Auscultation** (i.e., Clear, rales, location of rales, breath sounds); **Wheezing** i.e., On inspiration or expiration); **Retractions** (i.e., Where)

Breath sounds good - chest clear. No c/o pain or discomfort at present. Pharynx Red c̄ streaks of yellow-white exudate on enlarged tonsils.

6. **Cardiovascular — Heartbeat** (i.e., Regular or irregular); **Peripheral Pulses** (i.e., Dorsalis pedis and posterior tibial); **Edema** (i.e., Pre-tibial and pre-sacral); **Neck veins** (i.e., Distended or flat)

Heart beat Regular, rapid (122). (RT) DP and PT pulses of slightly weaker quality Than (LT). Both feet cool - cap. fill good. Neck veins flat.

7. **Abdomen** (i.e., Distended, flat, hard, soft); **Bowel Sounds** (i.e., Present or absent); **Bowel Habits** (i.e., Frequency, color)

Abdomen soft, bowel sounds present. usually i BM PER DAY.

LEARNING ACTIVITIES - continued

8. **Ears** (i.e., Hearing impairment, hearing rt._____ lt._____); **Eyes** (i.e., Visual impairment, ***glasses, contact lenses;*** artificial rt._____ lt._____) **Prosthesis** (i.e., Dentures, artificial limb)

WEARS CONTACT LENS/GLASSES (only has glasses c̄ on admission). OWN TEETH - FULL SET. No Problems hearing.

9. **Urine** (i.e., Frequency, burning, nocturia, hematurial)

Has had NOCTURIA Last 2 nights (up X2 during night). C+A have been 4+, NEG FOR last two days.

10. **Sleeping Pattern** (i.e., Sleeping pill, hours you sleep, time you retire and awaken, difficulty awakening)

usually Retires 10-12 PM AND SLEEPS STRAIGHT THROUGH UNTIL 5^{15} AM (Alarm Clock). NOT SO FOR the last 2 nights (NOCTURIA)

11. **Nutritional Habits** (i.e., Meals per day, special diet, snacks, preferences. Drinking, smoking habits). ***Inform patient of meal times.*** Does patient want smoking or non-smoking room, or no preference?

3 meals/day. Approx. 2000 cal. ADA DIET. DOES NOT SMOKE. occasional drink socially EVENING SNACK. NON-smoking Room.

12. **Religious or Personal Preference** (i.e., Jehovah Witness—Do you object to blood? Do you want visitors?)

Lutheran. no objections to blood. Prefers only immediate family and close FRIENDS to visit. IS AN R.N.

13. **Allergies** (i.e., To what? If a reaction, please describe specifically. Is allergy band on?)

Allergic to Keflin. Had Reaction to tetnus toxoid in May 76 (Hospitalized c̄ fever 104° stiff neck, headache, photophobia, nausea + vomiting).

14. **Medications** (i.e., Those brought to hospital; disposition of meds; medications taken at home)

TAKES 30-40 units NPH insulin daily at approx $6\text{-}7^{30}$ AM. ON NORLESTRIN ṫ mg. vitamins E, A and D, B complex c̄ C, Brewers yeast, Mg and Ca.

15. **Describe Chronic Health Problems** (i.e., Diabetes, epilepsy, asthma) Past History: Appendectomy 1952 Repair Urethra Divert. 1973

DIABETES mellitus (1966) Check urine c̄ C and A QID (AC + HS Double void). Regulate amt of ins. Diet + activity. usually covers c̄ sliding scale (REG. INS.) DURING illness or excessive stress twice daily

Admitted by: Rebecca Jefferson, RN

TRACE - 0
1+ 5 U REG INS.
2+ 10 "
3+ 15 "
4+ 20 "

STARTED SLIDING SCALE LAST NIGHT 4 PM and today at 7^{30} AM TOOK 20 U REG. INS.

EXAMPLE 2 (Nursing Assesment Form)—*Teaching Sample Only*

NOTE: Complete all blanks and circle appropriate answer in black ink

Date____________ Time arrived_______________

Name______________________ Age__________

Identiband checked with patient yes no

Hearing aid R / L none

Dentures upper lower partial none

T_____
P_____
R_____
BP____
HT____
WT____

Valuables
In safe yes no
With patient (list)
____
actual estimated

Vision aid
Glasses yes no
Contact lenses
yes no
R / L

Other artificial body part (pacemaker)
(eye R / L) leg R / L) arm R / L)
____
Orientation to room yes no
See checklist on back
Signature

Patient's reason for admission (and complaints)

Conditions and symptoms (nurse's observations)

Patient's knowledge of other health conditions

Diet restrictions
Diabetic
Other _______________
Allergies
Meds
Other

Medications
Routinely taken
Heart
Cortisone
Location of own meds
Bedside
Sent home
Pharmacy

Person to notify in case of emergency:
Phone:
Names of Doctors notified and time:
____
Signature:

Stencil

Nursing Assessment

NURSING ASSESSMENT FORM (continued)—*Teaching Sample Only*

ORIENTATION TO ROOM (Checklist)

INTRODUCE SELF and POSITION ______________

INTRODUCE OTHER PATIENTS ______________

EXPLAIN:

CLOSET & DRAWER SPACE ______________

BEDSIDE STAND—OVERBED TABLE ________

HI-LO BED—SIDE RAIL POLICY ___________

CALL LIGHT ______________

BATHROOM ______________

BEDSIDE LIGHT ______________

TV CONTROL ______________

TELEPHONE ______________

MEAL TIMES ______________

T. P. R. TIMES ______________

VISITING POLICY ______________

OTHER:

__________________________ ______________

__________________________ ______________

EXAMPLE 3—*Teaching Sample Only*

NURSE'S ADMISSION NOTES

PATIENT'S NAME ____________________

DATE ________ ARRIVED ________ a.m. p.m. FROM ____________

ROOM No. ______ BED No. ______ HOW ARRIVED: Walked ____ Stretcher ____

WHEELCHAIR ____ AMBULANCE ____ Name of Ambulance ____________

ACCOMPANIED BY ____________ RELATIONSHIP ____________

DID YOU INTRODUCE YOURSELF, GREET AND WELCOME THE PATIENT? DID YOU INTRODUCE YOUR PATIENT TO THE OTHER PATIENT IN THE ROOM?

HEIGHT ________ WEIGHT ________ TEMP ________ PULSE ________ RESP ________ BP ________

HISTORY OF: ASTHMA? ________
DIABETES? ________
EPILEPSY? ________

DO YOU WEAR — DENTURES? ________
ARTIFICIAL EYE? ________
CONTACT LENS? ________
ARTIFICIAL LIMB? ________
GLASSES? ________
OTHER? ________

URINE SPECIMEN COLLECTED? YES ______ NO ______

ALLERGIC TO: MEDICINES ____________________
(NAME) FOODS ____________________
OTHER ____________________

CONDITION OF HAIR ____________ NAILS ____________ SKIN ____________

OTHER OBSERVATIONS ____________________

PATIENT'S CHIEF COMPLAINT ____________________

____

VALUABLES TO SAFE? ____________
(YES or NO)

LIST: ____________
____
____
____
____
____

KEPT AT RESIDENCE? ____________
(YES or NO)

LIST: ____________
____
____
____
____
____

CLOTHES AT UNIT: (LIST)

____
____
____
____
____
____

MEDICATIONS BROUGHT TO HOSPITAL ____________
(YES or NO)

LIST: ____________
____
____

(If YES, Medications Taken to Medication Room?) YES or NO ________

EXPLANATION OF: INTERCOM & BELL CORD ______
OXYGEN OUTLET ______
TELEVISION ______

HI-LO BED ____________
SELECTIVE MENU ____________
TELEPHONE ____________

BEVERAGE DESIRED: ____________________

ADMITTED BY: ____________________

FIRST SEEN AND EVALUATED BY RN ____________________
(SIGNATURE) (DATE) (TIME)

SIGNATURE OF PATIENT ON ADMISSION ____________________

Example 4—*Teaching Sample Only*

PERSONAL BELONGINGS SHEET

STENCIL

Admitted by: **Date:** ______________________________

Received by: **Date:** ______________________________

DISPOSAL OF VALUABLES: **Date**__________

Rings ____________________
Watch____________________
Glasses ____________________
Meds. ____________________
Contact Lenses ____________________
Other Valuables: ____________________
Wallet with Contents: **Money $**__________
Credit Cards:______________________________

	NO	YES
DENTURES	______	______
Lower	______	______
Upper	______	______

LOCATION OF DENTURES:
Cup__________
Home with__________

Transferred by: **Date:** ______________________________

Received by: **Date:** ______________________________

DISPOSAL OF VALUABLES: **Date**__________

Rings ____________________
Watch____________________
Glasses ____________________
Meds. ____________________
Contact Lenses ____________________
Other Valuables: ____________________
Wallet with Contents: **Money $**__________
Credit Cards:______________________________

	NO	YES
DENTURES	______	______
Lower	______	______
Upper	______	______

LOCATION OF DENTURES:
Cup__________
Home with__________

Transferred by: **Date:** ______________________________

Received by: **Date:** ______________________________

DISPOSAL OF VALUABLES: **Date**__________

Rings ____________________
Watch____________________
Glasses ____________________
Meds. ____________________
Contact Lenses ____________________
Other Valuables: ____________________
Wallet with Contents: **Money $**__________
Credit Cards:______________________________

	NO	YES
DENTURES	______	______
Lower	______	______
Upper	______	______

LOCATION OF DENTURES:
Cup__________
Home with__________

Example 5—*Teaching Sample Only*

DISCHARGE PLANNING QUESTIONNAIRE*

NAME________________________________ ROOM_______________

Health care extends beyond your time in the hospital. There is a discharge planning service provided for you. In order to assist you in planning for your discharge from the hospital, please answer the following:

Do you live alone? Yes________ No________

After you are discharged from the hospital, do you expect to have problems with:

Meals? Yes________ No________

Housekeeping? Yes________ No________

Personal or Nursing Care? Yes________ No________

Shopping? Yes________ No________

Transportation? Yes________ No________

Other? Yes________ No________

Are you presently receiving service from any social agency? Yes________ No________

(If YES, please list agency or agencies below:)

____

____

____

____

*This form is used by Social Services only in planning and/or arranging discharge.

NURSING ASSISTANT SKILLS

Module M2 - Discharge

RATIONALE

The exit of a patient from a health care facility is called discharge. As a health care worker, you will need to know that upon leaving the health care facility, the patient must have all of the information and supplies needed for care at home, as well as all personal belongings.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Demonstrate preparation of a patient for discharge from the health care facility.
2. Demonstrate procedure for discharge of a patient from the health care facility.
3. Participate in a group meeting.
4. Become familiar with discharge forms.

LEARNING ACTIVITIES

ACTIVITY #1. Suggested Guidelines for Discharge

Directions: Read the following.

1. Assist patient with preparations for discharge.
    a. Inquire of patient or family member what time it is expected the patient will be leaving the health care facility.
    b. Locate patient's personal belongings, and verify on the personal belongings sheet.
    c. Help patient dress and pack belongings.
2. Proceed with discharge of patient.
    a. Confirm patient's discharge with ward clerk.
    b. Check with business office for release (ward clerk duty).
    c. Assist patient into wheelchair.

LEARNING ACTIVITIES - continued

d. Following discharge, report or record:

(1) Time of discharge

(2) How discharged (wheelchair)

(3) Accompanied by:

  (a) staff member (NA - auxiliary)

  (b) family or friend (wife, husband)

(4) Special information:

  (a) prescriptions

  (b) diet

  (c) activity

  (d) follow-up appointment

  (e) dressings and/or treatments

(5) Patient's condition upon discharge

Exercise.

Directions: In a group meeting with your instructor and other students, discuss the following questions and write your answers in the spaced provided.

1. When preparing for discharge, why should you help the patient get dressed?

____

____

2. After discharge, before taking the patient out of the hospital, what should you check? ____

____

____

3. How, and with whom, does the patient leave the hospital? ____________________

____

____

LEARNING ACTIVITIES - continued

4. Why is it important for a hospital employee to go out of the hospital with the patient? ______________________________

____

____

ACTIVITY #2. Hospital Forms

Directions: On the following pages of this module, you will find examples of two forms you will be asked to complete when you discharge a patient from the health care facility. Example #1 is a DISCHARGE PLAN; Example #2 is a DISCHARGE SUMMARY. The forms will vary according to the facility in which you are employed, but the information requested will be generally the same. Study the examples so you will be familiar with them when asked to complete a discharge form in your facility or a demonstration in your lab.

EXAMPLE 1—*Teaching Sample Only*

DISCHARGE PLAN

DISCHARGE Date________ Time________	**ACCOMPANIED BY** ________________	**DISCHARGED VIA** ________________

MEDS:

PRESCRIPTIONS:

DIET: (from floor personnel, physician or dietician)

DRESSINGS, TREATMENT, THERAPY:

ACTIVITY:

Work/School—
Drive
Bath

DR. APPOINTMENT:

Phone:________________

In case of questions or problems, call your physician

SPECIAL INFORMATION: (extended care, VNA, head sheet)

RECEIVED BELONGINGS, and received and understood this information.

Signature____________________

White Copy—Chart
Yellow Copy—Patient

Signature____________________
Hospital Personnel

EXAMPLE 2—*Teaching Sample Only*

DISCHARGE SUMMARY

I. KNOWLEDGE STATUS: Patient and/or Family Verbalizes and/or Demonstrates Understanding of:

A. MEDICATION REGIME: RX__________ To be taken__________

NO RX ☐ RX__________ To be taken__________

RX__________ To be taken__________

RX__________ To be taken__________

B. DIET: Regular ☐ Liquid ☐ Soft/Bland ☐ Other:__________

SOAKS Warm Q__________ Cool Q__________ Hot Q__________

CRUTCHES 3 Point Gait ☐ 2 Point Gait ☐ 4 Point Gait ☐ None ☐

DRESSINGS TO BE DONE Q:__________ **NONE:** ☐

CATHETER TO BE IRRIGATED Q:__________ **TO BE CHANGED Q:**__________

NONE ☐

EXERCISES:__________ **Q:**__________

(Order of Doctor)

FUTURE APPOINTMENT WITH DR.__________ **ON**__________ **AT**__________

(Name) (Date) (Time)

NO APPOINTMENT ORDERED: ☐

OTHER:__________

II SOCIAL DISPOSITION:

A. Living Arrangements Adequate: YES ☐ NO ☐

B. Necessary Referrals Have Been Made: YES ☐ NO ☐

C. Physical Therapy: ☐ Visiting Nurses: ☐

Welfare: ☐ Not Applicable: ☐ Other: ☐__________

D. Special Equipment Has Been Arranged For: BRACE ☐ CRUTCHES ☐ BED ☐

WALKER ☐ WHEELCHAIR ☐

NOT APPLICABLE ☐ OTHER:__________

III. EMOTIONAL STATUS:

A. Apprehensive: YES ☐ NO ☐

B. Fearful: YES ☐ NO ☐ If Fearful, of What? __________

C. Level of Anxiety: HIGH ☐ MODERATE ☐ LOW ☐

Comment if High: __________

IV. PHYSICAL CONDITION:

A. Vital Signs on Discharge: T__________ P__________ R__________ B/P__________

B. Residual Symptoms, if Any*__________

____

*If additional comments indicated, please record on Nursing Progress Record.

C. Condition of Surgical Wound: __________

Doctor Aware of Above? YES ☐ NO ☐ Comment: __________

V. PSYCHOLOGICAL STATUS: Oriented to Time, Place and Person: YES ☐ NO ☐

Comment, if No__________

PATIENT'S ADDRESSOGRAPH

__________RN/LPN

__________DATE

__________TIME

NURSING ASSISTANT SKILLS

Module M3 - Transfer

RATIONALE

Transfer is the moving of a patient from one patient unit to another. The purpose of the transfer is to place the patient on a unit better equipped to meet special needs. The doctor must order the transfer of a patient to a new unit. It will be your responsibility to assist with the transfer and make sure all personal belongings are also transferred.

PERFORMANCE OBJECTIVES

To the instructor's satisfaction, you will:

1. Describe steps in transferring patient from room to room.
2. Describe procedures in receiving a transfer patient.
3. Participate in a group discussion.
4. Become familiar with a transfer form.

LEARNING ACTIVITIES

ACTIVITY #1. Guidelines for Completing Transfer

Directions: Read the following.

1. Procedure for transfer of a patient from one unit or room to another.
    a. Locate patient's personal supplies and belongings.
    b. Validate belongings on personal belongings sheet.
    c. Pack all of the patient's personal supplies and belongings.
    d. Assist patient to cart or wheelchair.
    e. Accompany patient and T.L. to the new patient unit.
    f. Assist patient into bed.
    g. Verify with receiving unit the presence of personal belongings.
    h. Put patient's belongings and supplies where they belong.
    i. Introduce patient to nursing staff and roommates.
    j. Return cart or wheelchair to its proper place.

LEARNING ACTIVITIES - continued

2. Procedure for receiving transfer patient on your unit.

   a. Assist patient into bed.

   b. Introduce patient to staff members and roommates.

   c. Explain routines of new area to patient and family.

   d. Validate personal belongings sheet with staff member transferring patient.

   e. Note time, method of transportation, and general condition of patient at time of transfer. Report this information to the nurse in charge.

Exercise.

Directions: In a group meeting with your instructor and other students, discuss the following questions and write your answers in the spaces provided.

1. Give three reasons why a patient may be transferred.

   a. ______________________________

   b. ______________________________

   c. ______________________________

2. What do you take with the patient when making a transfer?

   ____

   ____

   ____

3. What becomes of, or is done to or with, the valuables envelope when a patient is transferred?

   ____

   ____

   ____

4. How is the patient prepared for transfer?

   ____

   ____

   ____

LEARNING ACTIVITIES - continued

5. Who prepares the patient for transfer?

ACTIVITY #2. Hospital Form

Directions: On the following page of this module is an example of a transfer form. It is similar to that used in most facilities. Study the example to familiarize yourself with what will be expected when you are asked to complete a discharge or transfer of a patient or complete a discharge demonstration in your lab.

EXAMPLE 1—*Teaching Sample Only*

TRANSFER FORM

Transferred by: Date:

Received by: Date:

STENCIL

DISPOSAL OF VALUABLES: Date__________

Rings __________
Watch__________
Glasses __________
Meds. __________
Contact Lenses __________
Other Valuables: __________
Wallet with Contents: Money $__________
Credit Cards:__________

	NO	YES
DENTURES	____	____
Lower	____	____
Upper	____	____

LOCATION OF DENTURES:
Cup__________
Home with__________

Transferred by: Date:

Received by: Date:

DISPOSAL OF VALUABLES: Date__________

Rings __________
Watch__________
Glasses __________
Meds. __________
Contact Lenses __________
Other Valuables: __________
Wallet with Contents: Money $__________
Credit Cards:__________

	NO	YES
DENTURES	____	____
Lower	____	____
Upper	____	____

LOCATION OF DENTURES:
Cup__________
Home with__________

Transferred by: Date:

Received by: Date:

DISPOSAL OF VALUABLES: Date__________

Rings __________
Watch__________
Glasses __________
Meds. __________
Contact Lenses __________
Other Valuables: __________
Wallet with Contents: Money $__________
Credit Cards:__________

	NO	YES
DENTURES	____	____
Lower	____	____
Upper	____	____

LOCATION OF DENTURES:
Cup__________
Home with__________

TERMINOLOGY

unit 8

The following is a list of terms, together with the definition of each. These are the terms you should recognize and understand for the successful completion of Unit 8 of the Health Occupations Program. Study and learn their meanings as related to the nursing assistant.

ACETEST:	Tablet used to test urine for acetones or ketones in the urine.
ACID FAST:	A specific test done to detect acid fast bacteria.
A.D.L.:	Abbreviation for activities of daily living.
ADMISSION:	The arrival of the patient on a unit in a health care facility.
AMPUTATION:	The surgical or accidental removal of a limb as the foot, hand, finger, toe, arm, or leg.
APNEA:	Without or the absence of air or breath.
AUTOPSY:	Examination of the patient's organs to determine the cause of death.
BACTERIA:	Microorganism; some may cause disease and others may not.
BANDAGE:	Length of material applied in a manner to fit a part of the body, usually an extremity.
BARIUM:	A soft, metallic element used to visualize the gastrointestinal tract in x-rays; barium may be swallowed or given as an enema.
B.I.D.:	Abbreviation meaning twice a day.
BINDER:	Piece of material specifically designed to fit a part of the body as the chest, abdomen, or the breasts.
BLANCHED:	Pale white color to the skin.
BLANCHING TEST:	To pinch and release the fingernails or toenails and to watch for the return of blood; done to test the patient's capillary blood return.
BLOOD PRESSURE:	The force exerted by the blood against the walls of the artery as it is pumped by the heart. BP is the abbreviation for blood pressure.

TERMINOLOGY - continued

BLOOD VOLUME:	The amount of blood flowing through the arteries and the veins.
BODY MECHANICS:	The way the body functions while you are standing, moving, and doing any job requiring physical effort.
CALCULI:	Stones.
CHEMICAL ANALYSIS:	A way of looking for a substance present in a specimen.
CHEYNE-STOKES RESPIRATIONS:	Respirations that become rapid and deep and then suddenly stop for a few seconds; may be experienced when the patient is approaching death. Stop/Go Respiration.
CLINISTIX:	Strip used to test the urine for glucose or sugar.
CLINITEST:	Tablet used to test the urine for glucose or sugar.
CONSCIOUSNESS:	The ability to observe, to understand, and to respond to the environment in an appropriate manner; controlled by the brain and by the involuntary nervous system.
CONSTIPATION:	Difficulty having a bowel movement; passage of hard and dry stool.
CONSTRICT:	To get smaller.
CONTRACTURE:	The deformity of a joint that results when the muscle which is flexing the joint becomes short and thickens and will not allow the joint to extend and the muscle that would extend the joint is stretched and weak.
CONVULSIONS:	Involuntary, uncontrolled, muscular contractions and relaxations.
CO_2:	Abbreviation for carbon dioxide.
CORONER:	An official who investigates the death of those who die from unknown or violent causes.
CULTURE:	A mass of microorganisms growing in a laboratory media or on food.
CUT DOWN:	Surgical incision through the skin to find a deeper vein and to insert a small catheter into the vein for intravenous therapy.

TERMINOLOGY - continued

CYANOTIC:	Bluish discoloration of the skin due to the lack of oxygen in the blood; may mean that blood is pooling and unable to get back to the heart.
CYSTITIS:	Inflammation of the urinary bladder.
CYTOLOGY:	The examination of cells; a test usually done to detect cancer cells.
DECUBITUS ULCER:	Pressure sore or bedsore; results from continuous pressure on one area of the body so that there is an interference with circulation.
DEFECATION:	Movement of stool.
DIARRHEA:	Frequent passage of watery stool.
DIASTOLIC PRESSURE:	The blood pressure at its lowest point; when the heart is relaxed between beats.
DILATE:	To get larger.
DISCHARGE:	The exit of a patient from a health care facility.
DYSPNEA:	Difficult or painful breathing.
EPILEPSY:	Seizure or "fit"; temporary disturbance in consciousness which may or may not be accompanied by convulsions; may be either grand mal or petit mal.
EXHALE:	To breathe out; air is forced back out of the lungs.
FECAL IMPACTION:	Hard stool or fecal material that blocks the colon and it cannot be expelled by the patient.
FEVER:	A temperature above normal.
FIXED PUPILS:	Pupils that do not respond to light.
FLATUS or FLATULENCE:	Gas in the digestive tract.
FLEX:	To bend.
FLUID BALANCE:	The same amount of fluid taken in by the body is also excreted.
FLUID INTAKE:	All of the fluids taken in by the body; sources may include water, ice chips, milk, juice, soup or broth, tea, coffee, ice cream, or jello.

TERMINOLOGY - continued

FOLEY CATHETER:	Retention catheter inserted into the bladder to drain urine; made so that it will stay in place within the bladder.
FOOT DROP:	Contracture of the ankle.
FORCE FLUIDS:	To encourage the patient to drink more fluids.
FRACTURE:	A broken bone.
FRENCH CATHETER:	Straight catheter used to drain urine from the bladder and is then immediately removed.
GANGRENE:	A serious form of necrosis that usually results when circulation is inadequate.
GUAIAC:	A test used to detect occult blood in stool.
HEMASTIX:	Strip used to test urine for blood.
HEMORRHAGE:	Loss of a large amount of blood; may be a slow loss or a sudden loss.
HEMORRHOIDECTOMY:	Surgery to remove hemorrhoid tissues.
HEMORRHOIDS:	A mass of dilated veins in the anus or rectum; may be external (protruding to the outside of the anus) or may be internal (not protruding).
HEMOSTASIS:	Clotting of blood.
HYPOSTATIC PNEUMONIA:	Pneumonia that develops because the mucus produced settles at the base of the lungs and is never adequately coughed up; frequently a complication of surgery.
HYPOXIA:	Lack of an adequate amount of oxygen in inhaled air.
I & O:	Abbreviation for intake and output.
INFILTRATION:	Condition where I.V. fluid infuses into the tissues under the skin instead of into the vein; the I.V. site will be swollen, cool to touch, and have a pale appearance.
INFUSING:	To run into; to introduce fluid into the vein.
INHALE:	To breathe in; air is sucked into the lungs.
INTRACRANIAL PRESSURE:	Pressure exerted on the brain.

TERMINOLOGY - continued

INTRAVENOUS:	Administration of fluids and medication into the vein.
I.V.:	Abbreviation for intravenous.
LABIA:	Folds of tissue that cover the vaginal area in the female.
LIQUID OUTPUT:	All of the fluids excreted by the body; sources include vomit, liquid diarrhea stool, and drainage from tubes inserted in the patient's body urine.
LUBRICATE:	To apply a gel, cream, or oil to help reduce friction.
MASTICATION:	The process of chewing food.
MEATAL CARE:	Same as perineal care; usually refers to the care given to a patient with a Foley catheter.
MEATUS:	The urinary opening; the opening of the urethra through which urine travels to the outside of the body.
MORTICIAN:	Undertaker; prepares the dead body for the funeral.
NECROSIS:	Death of tissue.
NORMAL RATES:	Vital sign rates that stay close to the same rate.
NORMAL SALINE:	Solution of distilled water and sodium chloride or salt -- the amount of salt mixed in the water is the equal amount.
O_2	Abbreviation for oxygen.
OBSTRUCTION:	Blockage.
OCCULT BLOOD:	Blood that is concealed; blood not visible to the naked eye.
ORAL HYGIENE:	Care of the mouth and teeth; done at least three times a day.
ORTHOPEDIC:	The science that deals with the treatment of conditions involving the skeleton and muscles.
ORTHOPNEA:	Respiratory condition where breathing is possible only when a person sits or stands in an erect (straight up) position.

TERMINOLOGY - continued

OSTEOMYELITIS:	Infection of the bone.
OVA:	Eggs.
PARALYTIC ILEUS:	Condition where the normal peristaltic movements of the intestine are temporarily paralyzed; patient unable to pass stool or flatus through the rectum and the intestine becomes very distended with excretions that cannot be expelled.
PARASITE:	An organism that lives and feeds off the patient.
PERINEUM:	Area including the penis, scrotum, and up to the anus in a male; vaginal area up to the anus in a female.
PERISTALSIS:	Involuntary, progressive, wave-like movements that occur in the hollow tubes of the body as the digestive tract works.
PIVOT:	To turn the body by moving the feet rather than by twisting at the waist or hips.
P.M. CARE:	Preparing the patient for sleep.
PODIATRIST:	A foot doctor.
POSTMORTEM:	After death.
POSTOPERATIVE:	After surgery (post-op).
PREOPERATIVE:	Before surgery (pre-op).
P.R.N.:	As desired or as needed.
PULSE:	The force of the heart. As the heart beats, blood is forced into the arteries and pushes against the arterial walls causing them to expand.
PULSE RATE:	The number of heartbeats per minute.
PULSE RHYTHM:	The regularity of the pulse beats.
PURULO-SANGUINEOUS:	Drainage with a bloody appearance mixed with pus.
Q.D.:	Abbreviation meaning once a day.
Q.I.D.:	Abbreviation meaning four times a day.
Q.4.H.:	Abbreviation meaning every four hours.

TERMINOLOGY - continued

Q. 15 min. x 6:	Abbreviation meaning every fifteen minutes for six times.
RANGE OF MOTION:	The extent of motion within a joint.
RENAL:	Word referring to the kidney.
RESP.:	Abbreviation for respiration.
RESPIRATIONS:	The process of inhaling and exhaling air.
RESPIRATORY RATE:	The number of respirations each minute.
RETENTION:	Retaining in the body that which does not belong there or which should be excreted.
RIGOR MORTIS:	The stiffness of the body and the limbs that occurs after death.
ROUTINE VITALS:	Vital signs taken four times a day.
SANGUINEOUS:	A drainage with a bloody appearance.
SERO-SANGUINEOUS:	A drainage with a bloody appearance mixed with serum.
S.G.:	Abbreviation for specific gravity.
S.O.B.:	Abbreviation for short of breath.
SPECIFIC GRAVITY:	Test done to determine the ability of the kidneys to concentrate or dilute urine according to the needs of the body.
SPHYGMOMANOMETER:	Instrument used to measure the blood pressure.
SPUTUM:	Expectorated bronchial secretions that occur when there is disease or irritation involving the trachea, bronchi, or the lungs.
SQUAT:	To move closer to the floor from a standing position by bending the knees and the hips and keeping the back straight.
SSE:	Abbreviation for soap suds enema.
STERILE:	Free of all bacteria.
STETHOSCOPE:	An instrument used to listen to sounds in the body as the heartbeat or the breathing in the lungs.

TERMINOLOGY - concluded

SUPRAPUBIC CATHETER:	A catheter inserted into the bladder through the lower abdominal wall to drain the urine.
SYSTOLIC PRESSURE:	The blood pressure at its highest point, when the heart is beating. Contraction of the heart - the first sound you hear.
TEMPERATURE:	The measurement of the balance between the heat produced by the body and the heat lost.
TES-TAPE:	Paper tape used to test urine for glucose or sugar; most frequently used if the patient is on certain drugs such as antibiotics that are excreted in urine.
THERMOMETER:	An instrument used to measure body temperature; may be either oral or rectal.
THROMBUS:	Stationary blood clot.
T.I.D.:	Abbreviation meaning three times a day.
TPR:	Abbreviation for temperature, pulse, respirations.
TRACTION:	A pulling force in opposing directions used to prevent muscle contractions in the treatment of some muscular deformities and in the treatment of fractures.
TRANSFER:	The moving of a patient from one patient unit to another.
TWE:	Abbreviation for tap water enema.
UREA:	Waste product from the metabolism of protein foods that is excreted as part of the urine.
URINOMETER:	An instrument used to measure specific gravity.
VAGINAL DOUCHE:	The regulated flow of solutiuon into the vaginal canal.
VAGINAL IRRIGATION:	Same as a vaginal douche.
VASOCONSTRICTION:	Blood vessels contract to become smaller to decrease the blood supply to an area.
VASODILATION:	Blood vessels get wider to increase the blood supply to an area.
VITAL SIGNS:	Temperature, pulse, respirations, and blood pressure.

POST TEST

Module A

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

1. A patient with a high fever and chills has complaints of abdominal pain, is nauseated and vomiting as much as two or three times every hour. This patient has an I.V. in the left hand and did not sleep well during the night. What type of bath would you give this patient?

   a. set the patient up to do his own partial bath
   b. give a partial bath
   c. give a complete bath
   d. help him with a quick bath at the bathroom sink

2. To give a towel bath, you must use a special solution called:

   a. Alpha-keri
   b. Dermassage
   c. Septi-soft
   d. Phiso-hex

3. You have a patient who had surgery yesterday to repair a broken bone in her leg. The leg is in traction and there is an I.V. in her right hand. What type of bath would you give this patient?

   a. set the patient up to do her own partial bath
   b. give a partial bath
   c. give a complete bath
   d. give a complete bath but do not turn her to wash her back

4. If you are asked to give a partial bath to a seriously ill patient, what parts of the patient's body will you bathe?

   1. hands
   2. underarms
   3. feet
   4. chest
   5. eyes and face
   6. legs
   7. genitalia (perineal care)
   8. back

   a. 1, 2, 3, 4, 8
   b. 3, 4, 6, 7
   c. 1, 2, 5, 7, 8
   d. 3, 5, 6, 8

POST TEST - continued

5. You are asked to set a patient up to give her own partial bath. What parts of the patient's body will you assist in bathing?

   1. hands
   2. underarms
   3. feet
   4. chest
   5. eyes and face
   6. legs
   7. genitalia (perineal care)
   8. back

   a. 1, 2, 5
   b. 3, 6, 8
   c. 4, 7, 8
   d. 2, 5, 7

6. You have a patient who has had surgery. He has an I.V. in one hand, a tube in the nose connected to a suction machine, and a Foley catheter draining his urine. What type of bath would you give this patient?

   1. set up to do his own partial bath
   2. partial bath
   3. complete bath
   4. towel bath

   a. any of the above
   b. 2 only
   c. either 1 or 2
   d. 3 only

7. You have a patient who is in the hospital for tests. She has been complaining of dizziness and of "black-out spells" at home. What type of bath would you give this patient?

   a. set up to do her own partial bath
   b. help her with a quick bath at the bathroom sink
   c. complete bath
   d. tub bath

8. While giving a bath, you notice that your patient has an area above the I.V. needle on her arm that is red and warm to touch. She tells you that the area burns. As a nursing assistant, what would you do?

   a. turn off the I.V. immediately
   b. slow the I.V. drip down
   c. report your observations to the nurse in charge
   d. tell her to keep her arm elevated on a pillow at all times

9. The doctor has ordered "TPR qid". What does that order mean?

   a. time pulse rates four times a day
   b. temperature, pulse, respirations four times a day
   c. temperature, pulse, respirations three times a day
   d. temperature, pulse, respirations twice a day

POST TEST - continued

10. You work on the morning shift or from 0700-1500. The doctor has ordered vital signs "tid". How often will you take this patient's vital signs on your shift?

    a. two times
    b. three times
    c. four times
    d. once

11. When the doctor orders vital signs "qd", how often are they taken?

    a. twice a day
    b. three times a day
    c. four times a day
    d. once a day

12. The doctor has ordered "BP q4h". What does that order mean?

    a. blood pressure every four hours awakening the patient at night
    b. blood pressure four times a day so he does not need to be awakened at night
    c. bathroom privileges four times a day but not at night
    d. blood pressure every four hours but do not awaken the patient at night

13. You work on the morning shift or from 0700-1500. The doctor has ordered vital signs "bid". How often will you take this patient's vital signs on your shift?

    a. two times
    b. three times
    c. four times
    d. once

14. How can you tell the difference between a rectal thermometer and an oral thermometer?

    a. the oral thermometer will have an end that is colored red
    b. the rectal thermometer will have an end that is colored red
    c. the rectal thermometer will have a long pointed tip
    d. the rectal thermometer will have an end that is colored blue

15. The normal oral temperature is:

    a. 97.6° F (36.5° C)
    b. 99.6° F (37.6° C)
    c. 98.6° F (37° C)
    d. 96.8° F (36° C)

16. When taking an oral temperature, how long is the thermometer left in the mouth?

    a. three minutes
    b. five minutes
    c. ten minutes
    d. six minutes

POST TEST - continued

17. An axillary temperature is taken with which kind of thermometer?

    a. rectal
    b. oral

18. The normal axillary temperature is:

    a. 97.6° F (36.5° C)
    b. 99.6° F (37.6° C)
    c. 98.6° F (37° C)
    d. 96.8° F (36° C)

19. How far would you insert a rectal thermometer into the rectum of an adult?

    a. just past the bulb tip
    b. 2 inches
    c. 1 to 1½ inches
    d. up to the 100° mark

20. The normal rectal temperature is:

    a. 97.6° F (36.5° C)
    b. 99.6° F (37.6° C)
    c. 98.6° F (37° C)
    d. 96.8° F (36° C)

21. You have a convalescent patient who has not been running a fever for the last three days. The doctor told him that morning that he would be going home tomorrow. When you take his temperature orally, it is 103.6° F. What is the first thing you would do?

    a. recheck the temperature charge
    b. record it immediately so the doctor can see it
    c. request the nurse to call the doctor
    d. ask the patient if he had been drinking hot tea or coffee.

22. A rectal temperature is taken on patients who:

    a. have had abdominal surgery
    b. are receiving intravenous therapy
    c. can breathe adequately with their mouth closed
    d. cannot understand and follow directions

23. When a patient's pulse skips beats, the rhythm has become:

    a. regular
    b. rapid
    c. irregular
    d. intermittent

POST TEST - continued

24. The most common place to count a patient's pulse is the:

    a. carotid artery
    b. radial artery
    c. temporal artery
    d. apical artery

25. The artery in the neck where the pulse can be taken is called the:

    a. carotid artery
    b. radial artery
    c. temporal artery
    d. femoral artery

26. When a pulse does not have a regular beat, you should listen to the heart with a stethoscope. This type of pulse is called the:

    a. carotid pulse
    b. radial pulse
    c. temporal pulse
    d. apical pulse

27. If you count the pulse for fifteen seconds, you should then:

    a. multiply that number by two
    b. divide that number by four
    c. multiply that number by four
    d. record the number you counted

28. The normal pulse:

    a. is 60-70 beats per minute for men
    b. is 70-80 beats per minute for women
    c. has a regular rhythm
    d. all of the above

29. When you count a patient's respirations, you will:

    a. count an inhale as one respiration and an exhale as a second respiration
    b. observe the character of respirations as well as the rate
    c. explain to your patient that you will be counting the respirations so that he will be completely relaxed
    d. immediately report to the nurse in charge a respiratory rate of 16

30. When you measure the blood pressure, you are measuring the force of the blood in:

    a. a vein
    b. the heart
    c. an artery
    d. the carotids

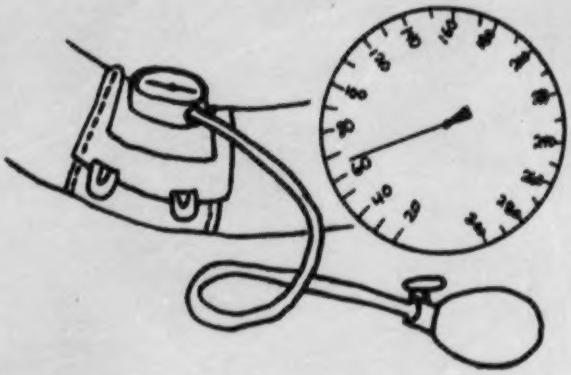
POST TEST - continued

31. When you take a blood pressure, the first clear sound you hear is called the:
    - a. systolic pressure
    - b. pulse pressure
    - c. diastolic pressure
    - d. volume pressure

32. The normal blood pressure for an adult is:
    - a. 110/70
    - b. 130/80
    - c. 120/95
    - d. 120/80

33. You have a patient who is hemorrhaging from an ulcer in the stomach. What will happen to the blood pressure?
    - a. it will go up
    - b. it will go down
    - c. the difference between the systolic and the diastolic will get smaller
    - d. the difference between the systolic and the diastolic will get greater

34. This instrument is called a:
    - a. stethoscope
    - b. sophthalmoscope
    - c. sphygmomanometer
    - d. scrotomameter



35. This instrument is called a:
    - a. stethoscope
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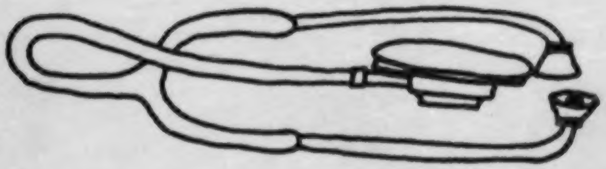

POST TEST - continued

SITUATION: You have a patient who was admitted with nausea and vomiting. The doctor decided to insert a tube through the nose into the stomach. The tube was connected to a suction machine. Your patient cannot eat or drink anything except for ice chips and has an I.V. in the hand. Questions 36 and 37 pertain to this situation.

36. You will be responsible for measuring this patient's output. What are some of the sources of liquid output that you will need to measure?

1. urine
2. stool
3. drainage on the dressing
4. drainage from the tube in the nose
5. diaphoresis
6. vomit

a. 1, 2, 3, 4
b. 4, 5, 6
c. 2, 4, 6
d. 1, 4, 6

37. You must also measure this patient's intake. What will this patient's intake include?

1. ice chips
2. jello
3. milk
4. I.V. fluid
5. water
6. tea

a. 2, 5, 6
b. 4, 6
c. 1, 4
d. 1, 2, 5

38. You have a patient who has been nauseated. She refuses to eat anything but bread with chicken soup, ice cream, and sips of 7-Up. What will you measure for intake to mark on the I & O sheet?

a. 7-Up only
b. soup, ice cream, 7-Up
c. everything but bread and ice cream since neither is considered liquid intake
d. ice cream, bread, soup, 7-Up

POST TEST - concluded

SITUATION: Your patient, Mr. Brown, has been having frequent diarrhea stools and a high fever. He is voiding in small amounts. Questions 39 and 40 pertain to this situation.

39. What are the sources of liquid output from this patient that you will be responsible for measuring?

1. urine
2. liquid stool
3. drainage on the dressing
4. drainage from the tube
5. diaphoresis
6. vomit

a. 1, 3, 6
b. 4, 5
c. 2, 4, 6
d. 1, 2

40. The nurse in charge asks you to start forcing fluids on Mr. Brown. What are the reasons why Mr. Brown needs more fluids added to his normal intake?

1. he is having diarrhea
2. he has a bladder infection and needs to flush out his bladder
3. he has a fever
4. he is over hydrated

a. 1, 2, 3
b. 4
c. 1, 3
d. 1

ANSWERS TO POST TEST

Module A

1. b
2. c
3. d
4. c
5. b
6. d
7. a
8. c
9. b
10. a
11. d
12. a
13. d
14. b
15. c
16. a
17. b
18. a
19. c
20. b
21. a
22. d
23. c
24. b
25. a
26. d
27. c
28. d
29. b
30. c
31. a
32. d
33. b
34. c
35. a
36. d
37. c
38. b
39. d
40. c

POST TEST

Module B

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: You are assigned to care for a patient who has had one leg amputated and is to remain in bed. Questions 1 and 2 relate to this situation.

1. How often should you change the patient's position?

   a. at least every four fours
   b. only when the patient complains of pain or requests that her position be changed
   c. every two hours, but never wake her up at night to change her position
   d. at least every two hours

2. When you position this patient flat on her back with her head aligned in a straight line with the spine, you have placed her in what position?

   a. Supine
   b. Prone
   c. Sim's
   d. Trendelenberg

3. The nurse in charge tells you to keep your patient, Mr. Smith, in Fowler's position when he is in bed. You know that in Fowler's position, your patient will:

   a. be partially sitting
   b. have his head elevated at a 45° angle
   c. have his knees flexed slightly
   d. all of the above

4. Fowler's position may be ordered:

   a. to treat a patient in shock
   b. after an operation on pelvic organs
   c. when the patient has difficulty breathing
   d. when giving an enema

5. The nurse in charge tells you that your patient is in shock. What position is also called the "shock" position?

   a. Trendelenberg
   b. Sim's
   c. Orthopneic
   d. Fowler's

POST TEST - continued

6. Trendelenberg position helps to:

   a. relieve respiratory distress
   b. increase the blood flow to the brain
   c. constrict the blood vessels
   d. relieve pressure on the brain

7. When giving an enema, you should place the patient in what position?

   a. Trendelenberg
   b. Sim's
   c. Orthopneic
   d. Fowler's

8. Dr. Jones tells you that he plans to examine his patient's rectum and lower colon with a proctoscope. He asks you to get the patient in the proper position. What position would you place this patient in?

   a. Trendelenberg
   b. Fowler's
   c. Knee-chest
   d. Supine

9. In Sim's position, the patient is:

   a. sitting at a 45° angle
   b. lying on the back with the knees flexed and separated
   c. sitting at a 9° angle leaning forward resting on the overbed stand
   d. lying on the left side with the right leg drawn up to the waistline

SITUATION: Your patient, Mrs. Krip, is paralyzed on her right side. The nurse in charge asks you to give range of motion exercises to all of her joints. Questions 10 through 15 relate to this situation.

10. As you are doing the range of motion exercises, you remember that the shoulder is a ______________ joint.

    a. hinge
    b. gliding
    c. ball and socket
    d. pivot

11. When you encourage Mrs. Krip to assist with her exercises, she is doing ______________ range of motion.

    a. progressive
    b. limited
    c. passive
    d. active

POST TEST - continued

12. While moving Mrs. Krip's knee joint during range of motion exercises, you must:

    a. flex and extend the knee
    b. abduct and adduct the knee
    c. extend and hyperextend the knee
    d. rotate and deviate the knee

13. Moving Mrs. Krip's shoulder joint or hip joint away from her body is called:

    a. flexion
    b. extension
    c. abduction
    d. adduction

14. The type of joints which should be moved through internal and external rotation during Mrs. Krip's exercises are:

    a. hinge joints
    b. ball and socket joints
    c. gliding joints
    d. all of the above

15. Mrs. Krip is more likely to develop contractures in which joints?

    a. the joints on her right side
    b. the joints on her left side
    c. the joints in her neck
    d. the joints below her waist

SITUATION: Your patient, Mr. Frank, has a cast applied for a fracture of his ulna. Questions 16 through 19 relate to this situation.

16. Mr. Frank complains of a little numbness in a spot underneath the cast. You would:

    1. Explain to him that the numbness is probably due to the fracture and will go away as the bone heals.

    2. Feel his fingers for warmth, check his skin color, and ask him to move his fingers.

    3. Check his toes for capillary refill.

    4. Tell him to exercise his toes frequently to increase circulation which may help the numbness.

    5. Tell the nurse in charge

    a. 2, 5
    b. 3, 4, 5
    c. 3, 5
    d. 1, 2, 5

POST TEST - continued

17. While Mr. Frank's cast is drying, it should:

    a. be supported on pillows
    b. be covered with a blanket to prevent Mr. Frank from becoming cold
    c. never be handled in order to prevent finger indentations
    d. rest flat on the bed to prevent cracking

18. Mr. Frank complains that the cast edges are crumbling and the little pieces are making him itch underneath the cast. You would:

    a. apply vasoline to his skin as far up under the cast as possible
    b. give him a tongue blade to scratch under the cast when he needs to
    c. dampen the edges of the cast to try to remold them
    d. finish the edges of the cast with adhesive tape

19. You notice that a spot of drainage has seeped through Mr. Frank's cast. What would you do?

    1. notify the physician
    2. elevate the extremity on a pillow
    3. circle the spot, mark the time, and date it
    4. notify the nurse in charge

    a. 2, 3, 4
    b. 1
    c. 3, 4
    d. all of the above

20. Your patient, Mrs. Strain, is using continuous cervical traction. When caring for her, you should:

    a. add the weights all at one time to get an even pull
    b. keep her in proper body alignment on her back
    c. make sure that the direction of pull from the traction is in a straight line with her hips
    d. remove the traction when she feels like she has had enough

21. Skin traction that is applied to the leg for a fracture of the femur or for a dislocated hip is called:

    a. Russell's traction
    b. Cervical traction
    c. Pelvic traction
    d. Buck's traction

22. Skin traction which may be applied to relieve pain or muscle spasm from injury to the lower back is called:

    a. Russell's traction
    b. Cervical traction
    c. Pelvic traction
    d. Buck's traction

POST TEST - concluded

23. Which is applied directly into the cranium to treat fractures of the neck?

    a. Crutchfield tongs
    b. Steinman tongs
    c. Skin traction
    d. Cervical traction

24. In caring for a patient with skeletal traction, you must be very careful to:

    a. remove the traction at least every four hours to give skin care
    b. check the area around the tong or pin for possible infection
    c. turn the patient from side to side every two hours
    d. remove the traction only when the patient complains of pain

25. Two other types of skin traction include:

    a. Cervical traction/Crutchfield tongs
    b. Pelvic traction/Steinman pin
    c. Skeletal traction/Pelvic traction
    d. Russell traction/Cervical traction

26. Another example of skeletal traction is:

    a. Steinman pin
    b. Cervical traction
    c. Pelvic traction
    d. Russell traction

ANSWERS TO POST TEST

Module B

1. d
2. a
3. d
4. c
5. a
6. b
7. b
8. c
9. d
10. c
11. d
12. a
13. c
14. b
15. a
16. a
17. a
18. d
19. c
20. b
21. d
22. c
23. a
24. b
25. d
26. a

POST TEST

Module C

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: While giving Mrs. Brown a bath, you notice that she is developing a decubitus ulcer. Questions 1 through 5 relate to this situation.

1. Another name for a decubitus ulcer is:

   a. peptic ulcer
   b. necrosis
   c. pressure sore
   d. duodenal ulcer

2. Which symptom(s) made you think that Mrs. Brown was developing a decubitus ulcer?

   a. reddened area
   b. area warm to touch
   c. Mrs. Brown complained of a burning sensation
   d. all of the above

3. In planning your care for Mrs. Brown, you remember that decubitus ulcers develop as a result of:

   a. extended irritation or pressure to a part of the body
   b. giving improper baths which allow bacteria to grow on the skin surface
   c. pressure that alternates from one skin area to another
   d. exposing the skin surface to unnecessary changes in temperature

4. You also remember that the most common sites for the development of decubitus ulcers include the:

   1. sacrum
   2. thorax
   3. sternum
   4. hip
   5. elbow
   6. knee
   7. shoulder
   8. heel

   a. 1, 4, 5, 7, 8
   b. 1, 2, 4, 6, 7
   c. 1, 3, 5, 7
   d. 2, 4, 5, 6

POST TEST - continued

5. Your plan to care for Mrs. Brown involves treating her decubitus ulcer and preventing other decubitus ulcers from developing. This plan will include:

    1. changing her position at least every two hours
    2. applying sulfa ointment to the decubitus ulcer — qid
    3. massaging all common sites with lotion
    4. keeping the bed free of wrinkles
    5. encouraging her to remain still in bed to prevent friction to the area

    a. 1, 3, 4
    b. 3, 4, 5
    c. 1, 3, 4, 5
    d. all of the above

SITUATION: Your patient Mrs. One is very overweight. Questions 6 and 7 relate to this situation.

6. What body parts are common sites for bedsores in obese patients?

    1. the calves
    2. between the folds of the buttocks
    3. the inner legs
    4. the abdominal area
    5. under the knees
    6. under the breasts

    a. 1, 3, 4
    b. 2, 3, 6
    c. 4, 5, 6
    d. 2, 3, 4

7. One way to protect these areas is to:

    a. dust with corn starch
    b. pad areas with dry dressings or cotton balls
    c. encourage the patient to turn at least every two hours
    d. apply lotion lightly and then dust with baby powder

8. The nurse in charge discontinued the I.V. on your patient. You notice that the area where the I.V. needle was located is swollen. What can you do to help relieve the swelling and discomfort?

    a. elevate the upper arm so that the swollen part is below the heart
    b. apply a warm moist compress
    c. massage the area
    d. apply an ice compress

POST TEST - continued

SITUATION: Mr. Smith was admitted to the hospital with an infected foot wound. The doctor has ordered hot foot soaks for 15 minutes -- qid. Questions 9 and 10 relate to this situation.

9. You remember that heat helps to speed the healing process by:

   a. controlling the bleeding
   b. causing the blood vessels to constrict which increases the blood supply
   c. causing the blood vessels to dilate which increases the blood supply
   d. decreasing the possibility of pus forming

10. While soaking Mr. Smith's foot, you must remember to:

   a. check the temperature of the water with a bath thermometer
   b. soak the foot only as long as Mr. Smith requests
   c. add hot water while the foot is soaking to maintain the correct temperature
   d. soak the foot three times a day

11. An increased blood supply helps injured tissue by:

   1. increasing the food and oxygen supply to the cells
   2. decreasing the possibility of pus forming
   3. bringing in more white blood cells to kill bacteria
   4. controlling bleeding
   5. preventing swelling

   a. 1, 2, 3
   b. 1, 4, 5
   c. 1, 3
   d. all of the above

12. When cold is applied to an area of the body, it causes the blood vessels in that area to:

   a. contract
   b. dilate
   c. constrict
   d. collapse

13. An effect of a cold application is that the blood supply to the area is:

   a. increased
   b. decreased
   c. completely absent
   d. not effected

POST TEST - continued

14. Your neighbor shows you a small scratch on the hand that looks infected and asks you what to do. You tell her:

    a. to keep it covered with a bandaid
    b. that soaking the hand in hot water may help
    c. that applying ice compresses will help bring in more white blood cells to help kill the bacteria
    d. to apply sulfa ointment

15. This same neighbor brings her young son over for you to examine. She tells you that he has sprained his ankle and wants to know what to do. You tell her:

    a. that she is a pest and you are not a doctor
    b. to soak his foot in hot water and call the doctor
    c. to apply cold compresses and call the doctor
    d. to keep him in bed for the next 24 hours

16. Your patient, Mr. Moss, has had surgery to repair his broken nose. His doctor asks you to observe for bleeding from the nose and in the back of his throat. What else might the doctor order to help control the bleeding?

    a. cold compresses to the cheeks and the nose
    b. keep the head of the bed flat
    c. drink only warm fluids
    d. warm moist compresses to the forehead, cheeks, and the nose

17. Your patient has a boil on the buttock. When changing the hot compress, you notice that the skin is very red and she tells you that the area is very painful. You should:

    a. re-apply the compress because the redness is normal
    b. tell her that you will not apply the compresses again for the next 24 hours
    c. tell the medication nurse that she needs something for pain
    d. leave the compresses off and report your observations to the nurse in charge

18. A thermal cooling blanket may be ordered for a patient:

    a. to prepare him for surgery
    b. with an elevated temperature
    c. with a decubitus ulcer
    d. to sterilize the skin

19. Excessive heat applied to a wound:

    a. will make cells work harder and therefore heal faster
    b. will reduce swelling and pain
    c. will cause tissue damage
    d. help to coagulate blood and prevent bleeding

POST TEST - continued

20. You are caring for a patient who was in an automobile accident and has many small cuts on the face. The doctor has ordered cold compresses to the face wounds. What signs will you observe that may mean that the compresses are too cold?

    a. skin may be very pale and bluish
    b. excessive inflammation
    c. tiny blisters
    d. redness

21. When preparing patients for sleep, which patients would not necessarily need their bedside rails up at night?

    a. convalescent patients
    b. restless patients
    c. well-oriented patients
    d. all patients should have bedside rails up at night

22. When making rounds at 0400 to check on your sleeping patients, you find a patient awake. What can you do?

    1. help reposition him
    2. tell the medication nurse that he needs a sleeping pill
    3. give a back rub
    4. sit down to let him talk to you
    5. turn the TV on quietly to help distract him

    a. any of the above
    b. 1, 2, 3, 4
    c. 1, 3, 4
    d. 1, 2, 3

23. While preparing a patient for sleep, how often will you tell her you will be around to check on her?

    a. at least every half hour
    b. every hour
    c. only when a light goes on to avoid disturbing the other patients
    d. every two hours

24. If your patient, Joe Cough, complains that your checking on him at night awakens him and he is not getting enough sleep, you should:

    a. close his door for the rest of the night
    b. assure him that you will only check on him when he puts on his light
    c. get a special order from the doctor so that you will not have to check on him
    d. explain that you check on him for his safety and that you will try to be more quiet

POST TEST - concluded

25. In preparing a patient for sleep, you would:

    a. offer the bedpan or urinal
    b. straighten the sheets
    c. have the patient wash his face and hands and brush his teeth
    d. all of the above

ANSWERS TO POST TEST

Module C

1. c
2. d
3. a
4. a
5. a
6. b
7. a
8. b
9. c
10. a
11. c
12. c
13. b
14. b
15. c
16. a
17. d
18. b
19. c
20. a
21. d
22. c
23. a
24. d
25. d

POST TEST

Module D

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: The nurse in charge tells you to give your patient, Mrs. Stool, a tap water enema. Questions 1 through 3 relate to this situation.

1. You remember that a tap water enema is a:

   a. cleansing enema
   b. oil retention enema
   c. tidal wave enema
   d. fleet enema

2. Before giving the enema, you should first:

   a. position your patient in lithotomy position
   b. move your patient closer to the right side of the bed
   c. explain the procedure to your patient
   d. place your patient on the bedpan

3. Your patient asks you why she needs this enema. You know that a tap water enema may be given to:

   a. relieve flatus
   b. remove fecal material
   c. prepare a patient for an x-ray
   d. all of the above

4. An enema that may be given to relieve constipation is a:

   a. tidal wave enema
   b. fleet enema
   c. Harris Flush
   d. glucose enema

5. Your patient is to receive a tidal wave enema. When explaining the procedure for giving a tidal wave enema to your patient, you would tell her:

   a. the tidal wave enema will help to soften the stool so she can defecate easier
   b. that you will be inserting the tube only about 1½ to 2 inches so she should not be uncomfortable
   c. that you will be holding the enema can up to allow the solution to flow in and then lowering it to allow the solution to flow out
   d. that giving the enema should not take any longer than five minutes

POST TEST - continued

6. A tidal wave enema is given to:

   a. help soften the stool so that defecation is easier
   b. relieve flatus in the colon
   c. relieve constipation
   d. prepare a patient for a proctoscopic examination

7. When explaining the procedure for giving a fleet enema to your patient, you should tell him:

   a. to hold the solution at least 2 to 5 minutes until the urge to defecate is strong
   b. to hold the solution as long as possible to allow it to help to soften the stool
   c. to position himself comfortably on the right side
   d. that you will be holding the enema can up to allow the solution to flow in and then lowering the can to allow the solution to flow out

8. An oil retention enema is given to:

   a. relieve flatus in the colon
   b. prepare a patient for an x-ray
   c. help soften the stool so that defecation is easier
   d. prepare a patient for a proctoscopic examination

9. The nurse in charge tells you to give an SSE to your patient. You know that an SSE is:

   a. a sterile saline enema
   b. the same thing as an oil retention enema
   c. a type of fleet enema
   d. a soap suds enema

10. When giving the SSE, you would:

    a. explain to the patient that the solution should run in as quickly as possible and to let you know when she has had enough
    b. instruct the patient to take deep breaths as the solution runs in
    c. assure her that pain and some cramping is to be expected during this enema
    d.. tell her to hold the solution only about 2 to 5 minutes before trying to defecate

11. You are asked to insert a rectal tube into your patient. Your patient wants to know the purpose for the tube. You explain that:

    a. the tube will relieve flatus in the colon
    b. the tube helps to cleanse the colon of stool
    c. the tube is inserted to relieve gastric distention
    d. the tube is inserted to relieve gas in the duodenum

POST TEST - concluded

12. You have a patient who is possibly hemorrhaging from the stomach. What type of stool specimen might the physician order to help make a diagnosis?

    1. stool for ova
    2. stool for occult blood
    3. stool for guaiac
    4. stool for culture

    a. 2
    b. 1, 2, 4
    c. 2, 3
    d. 1, 2

13. If the doctor orders a stool for culture, he is asking that the stool be tested for:

    a. tape worms
    b. bacteria
    c. blood
    d. parasites

14. If the doctor is looking for an organism that lives in the intestinal tract and feeds off the patient, she will probably order a:

    a. stool for ova and parasites
    b. stool for guaiac
    c. stool for culture
    d. stool for bacteria

ANSWERS TO POST TEST

Module D

1. a
2. c
3. d
4. b
5. c
6. b
7. a
8. c
9. d
10. b
11. a
12. c
13. b
14. a

POST TEST

Modules E and F

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: Mrs. Asthma is very dyspneic and has orthopnea. She has an I.V. in her right hand and is using O_2. Her doctor has ordered:

O_2 per mask continuously
Bedrest--may use bedside commode
Soft diet--tap water only.

Questions 1 through 9 relate to this situation.

1. If Mrs. Asthma has dyspnea, you know she:

   a. has a bluish discoloration of her skin
   b. has difficulty breathing
   c. lacks an adequate amount of oxygen in her inhaled air
   d. does not breathe for short periods of time

2. In planning bath care for Mrs. Asthma, you will:

   a. help her with a quick tub bath during a time when she is not short of breath
   b. set her up for a partial bath at the bathroom sink
   c. set her up to do partial bath at the bedside
   d. give her a complete bath

3. During her bath, you notice that Mrs. Asthma has a bluish discoloration of the skin. What is this bluish discoloration called?

   a. hypoxia
   b. blanching
   c. cyanosis
   d. dyspnea

4. On what parts of the body will this bluish discoloration be most apparent?

   1. around the eyes
   2. lips
   3. ankles
   4. thoracic area
   5. nailbeds
   6. neck and chest
   7. earlobes
   8. hands

   a. 1, 3, 6, 7
   b. 2, 3, 5, 8
   c. 2, 5, 7
   d. 3, 6, 7

POST TEST - continued

5. O_2 is an abbreviation meaning:

   a. oxygen
   b. dioxide
   c. positive pressure breathing machine
   d. air

6. Because Mrs. Asthma has orthopnea, you will:

   a. only allow her to drink warm or hot fluids; never cold fluids
   b. place her in Fowler's position
   c. only use alcohol to rub her back; never powder or lotion
   d. roll the head of her bed straight up and have her lean forward on the overbed table

7. Mrs. Asthma will use oxygen:

   a. only when she is short of breath or wants it
   b. while in bed, but may take the mask off to get up in the room
   c. while in bed, but the mask should be removed to sponge off her face
   d. while in bed, but may take the mask off to use the bathroom

8. Cyanosis may be due to:

   a. hypoxia
   b. too much O_2 in her inhaled air
   c. dilated bronchioles
   d. tachycardia

SITUATION: Mr. Hart has congestive heart failure. His doctor has ordered "O_2 PRN SOB". Questions 9 through 14 relate to this situation.

9. The order "O_2 PRN SOB" means:

   a. dioxide frequently for shortness of breath
   b. oxygen when necessary to save on breathing
   c. positive pressure breathing frequently to save on breathing
   d. oxygen as needed for shortness of breath

10. Mr. Hart becomes very restless and confused. You:

    a. tell the nurse in charge he needs something to relax him
    b. remind him to stay in bed
    c. apply his oxygen
    d. request that his doctor be notified

POST TEST - continued

11. The nurse in charge asks you to observe Mr. Hart for symptoms resulting from a lack of oxygen. These symptoms include:

    1. increase respiratory rate
    2. slow, irregular pulse
    3. headache
    4. frequent sighing
    5. high blood pressure
    6. flushed face and lips
    7. fast pulse
    8. anxiety

    a. 1, 3, 5, 6, 7
    b. 1, 3, 4, 7, 8
    c. 2, 4, 5, 6, 7
    d. 3, 5, 6, 7, 8

12. If Mr. Hart suddenly stopped breathing, he would have:

    a. hypoxia
    b. orthopnea
    c. apnea
    d. dyspnea

13. If Mr. Hart became dyspneic, he may be more comfortable if you:

    a. turned up his oxygen
    b. offered him something warm to drink
    c. positioned him in Fowler's position
    d. changed his position every four hours

14. When Mr. Hart receives oxygen therapy, you will prepare his room by:

    a. hanging a "NO SMOKING" sign on the door to his room
    b. removing his cigarettes and his matches
    c. replacing his electric shaver with a straight edged razor
    d. all of the above

15. If the doctor orders a sputum for cytology, he is asking that the sputum be examined for:

    a. cancer cells
    b. bacteria
    c. tuberculosis
    d. pneumonia

POST TEST - continued

16. You have a patient admitted with pneumonia and the doctor is trying to determine what bacteria has caused the disease. What type of sputum specimen will the doctor order?

    a. sputum for acid fast
    b. sputum for culture
    c. sputum for cytology
    d. sputum for guaiac

17. You may need to collect a sputum for __________________________ on a patient with a diagnosis of tuberculosis.

    a. acid fast
    b. culture
    c. cytology
    d. guaiac

18. You know a patient may need intravenous therapy in order to:

    1. counteract a stroke
    2. supply extra fluids when the normal intake is low
    3. prevent an increase in blood volume
    4. supply extra fluids when the fluid output is greater than normal
    5. supply the body with additional nutrients

    a. 2, 4, 5
    b. 1, 2, 4, 5
    c. 2, 3, 4
    d. all of the above

19. You notice that the solution has stopped draining from the bottle into the drip chamber. You should:

    1. loosen the clamp on the tube slightly
    2. report what you see to the nurse immediately
    3. check to make sure there are no kinks and that the patient is not lying on the tubing
    4. lift the I.V. bottle from the hook on the I.V. pole and lower it below the infusion site

    a. 2, 3
    b. 2
    c. 1, 2, 3
    d. all of the above

20. You have observed a swollen, inflamed area at the I.V. needle site. This may mean the I.V. has:

    a. intraveined
    b. infiltrated
    c. infused
    d. intra-infused

POST TEST - concluded

21. As a nursing assistant you will be asked to take which action(s) during a blood transfusion:

    1. take the temperature before and after the blood has infused
    2. observe the patient closely for the first fifteen minutes of a transfusion
    3. obtain a urine specimen after the first hour of the transfusion
    4. take blood pressure and pulse every thirty minutes

    a. all of the above
    b. 2
    c. 1, 3, 4
    d. 1, 2

22. Which of these symptoms would you expect the patient to complain of with a blood transfusion reaction:

    1. chills
    2. headache
    3. abdominal distress
    4. increased temperature
    5. urticaria

    a. all of the above
    b. 1, 2, 3, 5
    c. 3, 4, 5
    d. 1, 3

ANSWERS TO POST TEST

Modules E and F

1. b
2. d
3. c
4. c
5. a
6. d
7. c
8. a
9. d
10. c
11. b
12. c
13. c
14. d
15. a
16. b
17. a
18. a
19. a
20. b
21. d
22. a

POST TEST

Module G

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: Mr. Stone was admitted to the health care facility with complaints of severe pain in his lower right side that radiated to his back. His doctor stated that he may have renal calculi and ordered you to insert a Foley catheter, strain all urine, and obtain urine for a routine examination. Questions 1 through 3 relate to this situation.

1. You know that a Foley catheter is:

   a. the same as a retention catheter
   b. used when the doctor wants the patient catheterized for a sterile urine specimen
   c. not to remain in the bladder
   d. inserted into the bladder through the abdominal wall

2. After straining Mr. Stone's urine, you notice a small, gray particle in the strainer. Your first reaction is to:

   a. press the particle to see if it is hard
   b. rinse the strainer and try straining the urine again
   c. ask Mr. Stone if he had flicked his cigarette ashes into the measuring cup
   d. take the particle to show the nurse in charge and send it to the laboratory

3. You collect the routine urine specimen and send it to the lab. Th next day you find the lab report on the chart and read it. You know that a normal sample of urine:

   a. contains albumin
   b. is acid
   c. is alkaline
   d. contains dissolved amino acids

4. How much of normal urine is water?

   a. 50%
   b. 96%
   c. 67%
   d. 80%

5. The remaining percentage of normal urine is made up of:

   a. albumin and salts
   b. excess vitamins and ketones
   c. urea and salts
   d. dissolved amino acids

POST TEST - continued

6. The cloudy particles that may settle at the bottom of a sample of urine especially when it is contaminated with bacteria are referred to as:

   a. urea
   b. epitheleal cells
   c. accumulus
   d. sediment

SITUATION: Mrs. Gutierrez was admitted to the health care facility with a diagnosis of cystitis. Questions 7 through 9 relate to this situation.

7. Before reading her chart, you suspect from the diagnosis that she has been complaining of:

   a. low abdominal pain, nausea, and burning on urination
   b. back pain radiating down her legs
   c. urine that has a foul odor and burning on urination
   d. cramping abdominal pain, hematuria, and diarrhea

8. While caring for Mrs. Gutierrez, you notice that she:

   a. has urinary retention and her bladder feels distended
   b. voids in large amounts of 350-500 cc and only voids about once a shift
   c. voids in amounts of 200-300 cc and her urine is a clear yellow color
   d. voids frequently in small amounts of 50-100 cc

9. Mrs. Gutierrez's doctor orders that a sterile urine for culture and sensitivity be obtained and sent to the lab. To obtain the specimen, you will need:

   a. a straight catheter
   b. a clean-catch kit
   c. a test tube
   d. a retention catheter

SITUATION: Mr. Jones was admitted to the health care facility with complaints of frequent voiding in small amounts, nocturia, and difficulty initiating urination. His diagnosis is "possible enlarged prostate". Questions 10 through 13 relate to this situation.

10. Mr. Jones' doctor orders that Mr. Jones be "cathed for residual urine". The type of catheter you will need is a:

    a. Foley catheter
    b. French catheter
    c. Retention catheter
    d. Suprapubic catheter

POST TEST - continued

11. The next day Mr. Jones went to surgery for a cystoscopy and possible transurethral resection of the prostate (TURP). He was returned to the floor with an I.V. in his left hand and bladder irrigations running continuously. Some reasons he may need continuous bladder irrigations are:

    1. to instill medications
    2. to prevent the catheter from becoming obstructed
    3. to prevent the accumulation of blood in the bladder
    4. to insure that the patient can void well

    a. 2, 3
    b. 3
    c. 1, 2, 3
    d. all of the above

12. Mr. Jones complains of "bladder spasms" and you notice some leaking of the urinary drainage from around the catheter. You would:

    1. give him meatal care
    2. check the tubing for kinks
    3. know that these symptoms indicate that there may be a blockage in the catheter
    4. explain that the spasms will relax if he relaxes and tell him to take some deep breaths

    a. 2, 3, 4
    b. 2, 4
    c. 1, 2, 3
    d. all of the above

13. The solution most commonly used for continuous bladder irrigations is:

    a. sterile distilled water
    b. normal saline
    c. 5% dextrose in water
    d. lactated ringer's solution

14. The reasons for the use of a Foley catheter are:

    1. to obtain a clean urine specimen
    2. to prevent the patient from voiding involuntarily
    3. to prevent the patient from voiding voluntarily
    4. to check the bladder for residual urine after voiding

    a. 1, 2
    b. 4
    c. 2, 3
    d. all of the above

POST TEST - concluded

15. When cleaning the genitalia in order to insert a catheter, you should:

    a. pour water over the labia
    b. use a washcloth to clean the area
    c. wipe upward with betadine soaked sponges
    d. wipe downward with betadine soaked sponges

16. When securing the catheter so that it does not become dislodged, you should:

    a. only pin the catheter on the bed
    b. internally rotate the leg and secure catheter to outer thigh
    c. externally rotate the leg and secure catheter to inner thigh

17. When a catheter is inserted into the bladder through an incision in the lower abdomen, the catheter is called:

    a. Nephrostomy catheter
    b. Foley catheter
    c. Suprapubic catheter
    d. Urinostomy catheter

SITUATION: Your patient, Mrs. Fail, was admitted with a diagnosis of congestive heart failure. She has a constant hacky cough and her respirations sound very congested. She has edema from her feet to her thighs, in her hands, and in her face around the eyes. You notice that she voids in small amounts and her urine is very dark amber in color. The nurse in charge asks you to measure the specific gravity of her urine. Questions below relate to this situation.

18. When you order the instrument from Central Supply to measure the specific gravity of her urine, you will ask for a/an:

    a. urohydrometer
    b. hydrofuge
    c. urocentrifuge
    d. urinometer

19. The normal specific gravity of urine is:

    a. 1.001 to 1.003
    b. 1.010 to 1.030
    c. 1.100 to 1.300
    d. 1.025 to 1.045

20. After measuring the specific gravity of Mrs. Fail's urine, you get a reading of 1.036. You know that this reading indicates:

    a. her urine is very concentrated
    b. you read it incorrectly -- the instrument is not gaged to get such a reading
    c. she is within normal limits of specific gravity
    d. her urine is very diluted

ANSWERS TO POST TEST

Module G

1. a
2. d
3. b
4. b
5. c
6. d
7. c
8. d
9. a
10. b
11. c
12. c
13. b
14. c
15. d
16. c
17. c
18. d
19. b
20. a

POST TEST

Modules H and I

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: Mrs. Lopez was admitted to the health care facility with diabetes. You are asked to do fractional urines when you do the clinitest and the acetest on this patient. Questions 1 through 8 relate to this situation.

1. You would know that the clinitest was ordered to:

   a. test the urine for albumin
   b. test the kidney function
   c. test the urine for glucose
   d. test the urine for ketones

2. You would expect Mrs. Lopez to have her urine clinitested because:

   a. diabetes is a disease that results in poor kidney function
   b. the diabetic patient is unable to metabolize sugar normally
   c. diabetes causes an increase in the amount of albumin secreted by the kidneys
   d. the diabetic patient usually has a low level of glucose in the blood

3. Mrs. Lopez wants to know why you use two different pills to test her urine. You tell her:

   a. the larger tablet is the clinitest tablet for testing glucose and the smaller tablet is for testing ketones in urine
   b. the smaller tablet is the clinitest tablet for testing glucose in the urine and the larger tablet is for testing acids in urine
   c. the larger tablet is the clinitest tablet for testing albumin in the urine and the smaller tablet is the acetest tablet for testing ketones
   d. the smaller tablet is the clinitest tablet for testing glucose and the larger tablet is for testing acetones in urine

4. The acetest is a test done to:

   a. test for acids in the urine
   b. test for acetones in urine
   c. test for ketones in urine
   d. both b and c

POST TEST - continued

5. To test for sugar in urine, you may use:

   a. clinitest
   b. clinistix
   c. tes-tape
   d. all of the above

6. Mrs. Lopez needs to have her urine acetested because:

   a. a diabetic patient has urine that is normally more acid
   b. her diabetes may interfere with the ability of the kidneys to excrete acetone
   c. ketone bodies appear in the urine when the diabetic patient must burn fat for energy
   d. diabetes is a disease that results in the overproduction of ketones by the pancreas

7. When would you clinitest and acetest Mrs. Lopez's urine?

   a. four times a day
   b. one-half hour before meals and at bedtime
   c. tid
   d. one hour before meals

8. When the doctor ordered that the urine tested be fractional, he is ordering you to:

   a. test every specimen the patient voids
   b. record the time the patient voids and the amount voided in addition to testing the urine
   c. test the urine voided one hour before meals
   d. have the patient empty her bladder one hour before each meal and then to test the second urine voided one-half hour before each meal

9. Your patient, Mrs. Vaginitis, was admitted to the health care facility with a vaginal infection and a white discharge. You are asked to irrigate her vagina with a medicated solution. Mrs. Vaginitis asks you why she needs this irrigation. You know that a vaginal irrigation may be done to:

   1. relieve inflammation
   2. cleanse the uterus
   3. treat vaginal infection
   4. cleanse the vaginal tract
   5. treat a uterine infection

   a. all of the above
   b. 2, 4
   c. 1, 3, 4
   d. 3, 4, 5

POST TEST - concluded

10. Your patient was admitted to the health care facility with her bladder protruding into the vagina. She went to surgery to have her bladder repositioned. After surgery, you are asked to give her vaginal irrigations every day. While you are doing the treatment, your patient asks if she needs this because she has developed an infection. You tell her:

    a. no, so she will not worry
    b. yes, vaginal irrigations are done to treat infection
    c. that vaginal irrigations are sometimes done to prevent infection and to ask her doctor
    d. that vaginal irrigations are always done routinely after her type of surgery

ANSWERS TO POST TEST

Modules H and I

1. c
2. b
3. a
4. d
5. d
6. c
7. b
8. d
9. c
10. c

POST TEST

Module J

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: You are caring for Mr. Corby who was in an automobile accident. You are asked to check his level of consciousness and his neuro signs. Questions 1 through 5 relate to this situation.

1. When you visit Mr. Corby, you find him sleeping. You call his name but he does not respond until you shake his shoulder. Then he opens his eyes briefly. You ask him where he is and he tells you he is busy working on his car. Mr. Corby is in which level of consciousness?

   a. semicomatose
   b. restless
   c. stuporous
   d. comatose

2. While checking his neuro signs you find that his right pupil reacts slower to light than his left pupil. This response to light is:

   a. normal
   b. abnormal
   c. expected because of the accident
   d. not unusual since his eyes have not been open to light for awhile

3. You also find that his left-hand grip is much weaker than his right. This response is:

   a. normal
   b. impossible since his right pupil was the one to react slower to light
   c. not unusual since he is right-handed
   d. abnormal

4. The nurse in charge asks you to watch Mr. Corby very closely and to check his neuro signs every fifteen minutes. When you return to his room, you find that he will not respond even when you pinch his fingers and squeeze his shoulder muscle. Mr. Corby is in which level of consciousness?

   a. restless
   b. stuporous
   c. comatose
   d. semicomatose

POST TEST - continued

5. A change in his level of consciousness may be due to:

   a. increased intracranial pressure
   b. a drop in his blood pressure
   c. tachycardia
   d. abnormal sinus pulse rhythm

6. Mrs. Caum has recently had surgery. When you visit her you find that she is very anxious and you notice some twitching in her legs. She yells at you to watch out for the snake that is about to drop on your head. Mrs. Caum is in which level of consciousness?

   a. alert
   b. restless
   c. stuporous
   d. comatose

SITUATION: Mr. Stroke has brain damage from a cerebral vascular accident (CVA) and is unable to speak. You have been caring for him for the last two days. Questions 7 through 10 relate to this situation.

7. When you visit Mr. Stroke, he smiles and seems glad to see you. You ask him if he would like to brush his teeth. He nods "yes", and holds out his hand for the toothbrush. Which level of consciousness is Mr. Stroke in?

   a. alert
   b. stuporous
   c. semicomatose
   d. impossible to say since he cannot talk to you

8. When you ask Mr. Stroke to stick out his tongue, you notice that it moves to the right side. You know that this is:

   a. probably why he cannot speak
   b. a normal neuro sign
   c. due to his change in the level of consciousness
   d. an abnormal neuro sign

9. When checking Mr. Stroke's neuro signs, you find that his right arm gradually moves downward when he is asked to lift his arms. You know that this response is:

   a. normal
   b. abnormal
   c. expected in CVA patients
   d. a sign of hypotension

POST TEST - continued

10. If during the neurological check, Mr. Stroke is able to lift both legs to the same height but only one at a time, his response is:

    a. normal
    b. abnormal
    c. expected in CVA patients
    d. a sign of hypotension

SITUATION: You have been caring for Mrs. Johns for two days. She was admitted to the health care facility after an automobile accident. Suddenly, her whole body becomes rigid and she falls to the floor. Her arms and her legs begin to jerk around and she turns very cyanotic. Questions 11 through 16 relate to this situation.

11. What type of a seizure did Mrs. Johns experience?

    a. brain seizure
    b. epileptic mal seizure
    c. grand mal seizure
    d. petit mal seizure

12. During the seizure, you remember that your care for Mrs. Johns is aimed at:

    a. controlling the seizure
    b. preventing her from hurting herself
    c. re-establishing her respirations
    d. stopping further spasms

13. The first thing you would do when Mrs. Johns starts her seizure is to:

    a. try to insert a spoon between her front teeth to prevent her from biting her tongue
    b. apply oxygen
    c. try to move her back to bed to prevent her from hurting herself
    d. put the emergency flasher on to get help

14. In caring for Mrs. Johns during her seizure, safety precautions will include:

    1. applying oxygen
    2. moving her to a softer surface
    3. loosening the clothing around her neck
    4. staying with her
    5. preventing her head from striking any hard surfaces

    a. 1, 4, 5
    b. 3, 4, 5
    c. 2, 3, 4, 5
    d. all of the above

POST TEST - continued

15. Some observations you will make during the seizure will include:

    1. the time the seizure started
    2. the pupil changes which occur
    3. the body parts involved
    4. the type of muscular contractions
    5. if the patient was incontinent during the seizure

    a. 1, 2, 4
    b. 1, 2, 4, 5
    c. 1, 2, 3, 4
    d. all of the above

16. Which safety precaution(s) will you need to practice during Mrs. Johns' stay in the health care facility?

    a. pad the bedside rails
    b. always accompany Mrs. Johns when she goes to the bathroom
    c. tape a padded tongue blade to the head of her bed
    d. all of the above

17. The type of epilepsy characterized by a brief loss of consciousness and twitching of the hands or face is:

    a. Jacksonian mal epilepsy
    b. Petit mal epilepsy
    c. Grand mal epilepsy
    d. Cranial epilepsy

SITUATION: Mr. Owner had surgery yesterday. He was found heading down the back stairs carrying his I.V. bottle with his Foley bag dragging behind him. The doctor ordered that he be restrained in bed. Questions 18 through 20 relate to this situation.

18. You remember that the reasons a patient may need to be restrained in bed include:

    1. to remind him that he is confused
    2. to protect you from the patient
    3. to prevent him from pulling out his I.V.
    4. to keep him from turning in bed
    5. to protect him from himself

    a. 1, 3, 5
    b. 3, 4, 5
    c. 2, 3, 5
    d. all of the above

POST TEST - concluded

19. Mr. Owner may be restrained in a type of restraint applied to the chest that limits movement from side to side and limits sitting up. This type of restraint is called a:

    a. hard restraint
    b. waist restraint
    c. mummy restraint
    d. posey restraint

20. After securing the restraint on Mr. Owner, you must remember to:

    a. position Mr. Owner on his back only
    b. tie the restraint to the bed frame
    c. remove the restraint only at bath time
    d. check him only when he calls so you do not further confuse him

ANSWERS TO POST TEST

Module J

1. c
2. b
3. d
4. c
5. a
6. b
7. a
8. d
9. b
10. a
11. c
12. b
13. d
14. b
15. d
16. d
17. b
18. c
19. d
20. b

POST TEST

Module K

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: You work on the night or 11 - 7 shift and you are asked to prepare Mrs. Gall for surgery. She is to have a cholecystectomy the next morning. Questions 1 through 6 relate to this situation.

1. You read the doctor's orders and find that she is to be "NPO p 2400." You tell her that:

   a. she can no longer have anything to eat or to drink
   b. she will not be allowed to drink any fluids after 2:40 A.M.
   c. she will not be allowed anything to eat or to drink after midnight
   d. she will not be allowed to drink fluids but will be able to have a dry breakfast in the morning to help build up her strength for surgery

2. You must also:

   a. remind her that she will not be able to brush her teeth in the morning since she will be NPO
   b. post an "NPO" sign on her door
   c. remember to take away her water pitcher and glass at midnight
   d. all of the above
   e. b, c only

3. When taking Mrs. Gall's vital signs at bedtime, you notice that she is coughing occasionally and has a temperature of 100° F. You would:

   a. report your findings to the nurse in charge since one of the complications of surgery is strep throat
   b. encourage her to force fluids until surgery the next morning to prevent her from becoming dehydrated by the temperature
   c. not be concerned since these are some of the symptoms of cholecystitis
   d. report your findings to the nurse in charge since her surgery may need to be postponed

4. You notice that Mrs. Gall is wearing nail polish. You:

   a. ask her to remove it and tell her not to put on makeup in the morning as these are not sanitary
   b. ask her to remove it and tell her not to put on makeup in the morning since the physician will need to see the true color of her skin and nails
   c. know that nail polish may be left on but tell her not to put on makeup in the morning
   d. are not concerned

POST TEST - continued

5. While preparing Mrs. Gall for some of the things to expect after surgery, you will:

   a. show her how to splint her chest to cough
   b. practice the procedure for dangling remembering that she will have an abdominal wound
   c. tell her she will be asked to move her legs and to turn in bed immediately after surgery and at least every two hours
   d. all of the above

6. Before Mrs. Gall goes to bed, you must:

   a. collect a routine urine specimen
   b. collect a clean catch urine specimen
   c. collect a CBC
   d. collect a urine specimen for clinitest and acetest

SITUATION: You are to prepare Mr. Pratt for surgery to repair an inguinal hernia. He is to receive his preoperative medication at 0900 and will leave for surgery at 0930. Questions 7 through 9 relate to this situation.

7. Mr. Pratt tells you that the last time he went to surgery, the shot they gave him before surgery made him break out in a rash. You:

   a. tell him that it is too late to tell his doctor since he is already scheduled for surgery
   b. are not concerned because you know his doctor has a list of his allergies
   c. tell him you will tell the nurse in charge
   d. tell him not to worry because he will not be getting the same medication

8. When writing the TPR on the pre-op checklist, you notice that the surgical consent was not timed when it was signed. You would:

   a. quickly fill in the approximate time
   b. tell the nurse in charge so a new consent can be signed
   c. find out from the patient what time he signed the consent and fill in the time
   d. be unconcerned since you know the nurse in charge will be checking the consent

9. After his shower, Mr. Pratt asks if he can dress in his own pajamas. You tell him:

   a. he must dress in a hospital gown
   b. he must wear the hospital pajamas
   c. he can wear his own pajamas as long as they are clean
   d. any of the above depending upon his preference

POST TEST - continued

SITUATION: After surgery, Mr. Pratt is returned to the floor with an I.V. in his left hand and a dressing. His doctor has ordered: V.S. q. 1 hr. x 4 -- clear liq. diet -- advance to regular as tolerated, stand at bedside with help to void. Questions 10 to 14 relate to this situation.

10. When you check on Mr. Pratt, you find that he is very drowsy. You should:

    a. report this to the nurse in charge
    b. have him cough and deep breathe every two hours until he is more responsive
    c. not be concerned since he is expected to be drowsy from the anesthesia
    d. encourage him to cough and deep breathe every 15 minutes

11. What postoperative complications will coughing and deep breathing help prevent?

    a. pulmonary emboli
    b. bronchitis
    c. hypostatic pneumonia
    d. laryngospasm

12. How often will you take Mr. Pratt's vital signs?

    a. every four hours for 24 hours
    b. every hour for four hours then every four hours
    c. four times a day for 48 hours
    d. every four hours for 48 hours

13. You know the purposes for Mr. Pratt's dressing may include:

    1. provide support to a weakened body part
    2. absorb secretions
    3. immobilize the area
    4. protect the surgical incision from trauma
    5. prevent infection from entering the wound

    a. 2, 4, 5
    b. 1, 2, 4, 5
    c. 2, 5
    d. all of the above

14. You should encourage Mr. Pratt to turn in bed and start moving his legs immediately after he is returned to the floor. This is to prevent what postoperative complication?

    a. paralytic ileus
    b. hypostatic pneumonia
    c. embolus
    d. thrombi

POST TEST - continued

SITUATION: Mrs. Lewis returned to your unit after an exploratory laparotomy. She has a tube positioned in her stomach through an incision in her abdomen which is connected to a Gomco suction machine. She has an I.V. in her left hand and an abdominal dressing. Questions 15 to 19 relate to this situation.

15. The nurse in charge asks you to watch Mrs. Lewis carefully for signs of hemorrhage. Which symptoms will indicate that Mrs. Lewis is hemorrhaging?

    1. rapid, irregular breathing
    2. low pulse
    3. low blood pressure
    4. complaints of excessive thirst
    5. hot and flushed
    6. nailbeds cyanotic
    7. complaints of excessive hunger
    8. restless
    9. rapid pulse

    a. 1, 3, 5, 7, 8, 9
    b. 2, 5, 6, 9
    c. 1, 3, 4, 6, 8, 9
    d. 3, 5, 6, 7, 9

16. The tube positioned in Mrs. Lewis' stomach is called a:

    a. nasogastric tube
    b. enterostomy tube
    c. gastrostomy tube
    d. cecostomy tube

17. A patient with this type of tube will:

    a. be on a full liquid diet
    b. need frequent mouth care
    c. be encouraged not to turn in bed to prevent the tube from becoming dislodged
    d. not be allowed to rinse out her mouth or gargle

18. One of the postoperative complications you will be observing Mrs. Lewis for is paralytic ileus. You know that:

    a. paralytic ileus can be prevented by turning the patient frequently and having her move her legs
    b. some signs of paralytic ileus include poor circulation in the feet and difficulty moving the legs
    c. some signs of paralytic ileus are an abdomen that feels hard and is distended and an inability to pass flatus
    d. both a and b

POST TEST - continued

19. Mrs. Lewis' doctor orders a scultetus binder to be applied when she is ambulated. You understand that the purpose for a binder includes:

    a. 1, 2
    b. 1, 2, 4
    c. 2, 3, 4
    d. all of the above

SITUATION: Your patient, Mrs. Breast, has had a mastectomy. She has Hemovac tubing in place. Questions 20 and 21 relate to this situation.

20. You know that a Hemovac is designed to:

    a. drain the bile produced by the liver
    b. prevent gastric distention
    c. relieve the accumulation of duodenal blood
    d. drain blood and fluid in the surgical area

21. You will be responsible for making sure that the Hemovac drains properly. To do this, you must:

    a. irrigate the tube every 2 to 4 hours
    b. reactivate the Hemovac at periodic intervals
    c. keep the bottle below the incision at all times
    d. gradually advance the tubing

22. The tube often inserted following a cholecystectomy to drain bile is called a:

    a. cystostomy tube
    b. Hemovac
    c. T-tube
    d. gastrostomy tube

23. If a patient has a penrose drain, you would expect:

    a. to change or reinforce dressings frequently
    b. the drain to be connected to a Gomco machine
    c. to irrigate the drain when it does not drain properly
    d. the patient to complain of frequent gas pains

24. When the physician gradually removes a penrose drain, she is ________________ the drain.

    a. reactivating
    b. graduating
    c. retracting
    d. advancing

POST TEST - concluded

25. The purpose of a nasogastric tube is to:

    a. drain the gall bladder
    b. drain fluid that accumulates in the incision
    c. to keep the stomach free of secretions
    d. to assist in the healing of tissues

ANSWERS TO POST TEST

Module K

1. c
2. e
3. d
4. b
5. d
6. a
7. c
8. b
9. a
10. d
11. c
12. b
13. a
14. d
15. c
16. c
17. b
18. c
19. a
20. d
21. b
22. c
23. a
24. d
25. c

POST TEST

Module L

Directions: Read each question and its lettered answers. When you have decided which answer is correct, circle that letter on your answer sheet. DO NOT WRITE ON THIS TEST.

SITUATION: Mr. Roth knows that he is dying of heart failure. He keeps his door closed and is asking to be left alone so that he may plan his funeral. Mrs. Roth cannot stand to listen to him make his plans. When visiting, she tries to be cheerful but must leave the room frequently to cry outside the door. She tells you, sobbing constantly, "I know he is dying, but I wish he would not be so morbid. We will make the plans for his funeral after he is gone." Questions 1 through 4 relate to this situation.

1. Mr. Roth is in what stage of dying?

   a. denial
   b. isolation
   c. bargaining
   d. acceptance

2. He tells you that he knows his planning for his funeral upsets his wife but he feels it is something he needs to do. He asks you for your help. You tell him:

   a. this is a family matter and it would be best if you did not get involved
   b. that you will help him with his plans since his wife is unable to do so
   c. that his wife already has plans for his funeral
   d. that he should be spending his last days talking with his wife, not with you

3. Mrs. Roth is in what stage of acceptance of death?

   a. denial
   b. anger
   c. depression
   d. bargaining

4. How can you help Mrs. Roth through this stage?

   a. tell her that her husband should be allowed to do as he pleases in his last days
   b. explain that this is just a stage that he passes through while dying and he will move out of this stage quickly
   c. explain to her that her husband is not morbid but just wants to save her the trouble of making funeral plans after he is dead
   d. find a place where she can feel free to talk with you and to cry

POST TEST - continued

5. Mrs. Karey has terminal cancer of the lung. One day you find her crying. She tells you, "I would feel much easier about going if I could just be at my son's wedding next week." Which stage of death is Mrs. Karey in?

   a. isolation
   b. bargaining
   c. depression
   d. acceptance

SITUATION: Mr. Krab has been told that he has terminal intestinal cancer. All of a sudden, he becomes impossible!! He puts his light on every five minutes wanting something else and if you do not answer immediately, he starts yelling and throws his urinal out into the hall. Questions 6 and 7 relate to this situation.

6. What stage of dying does this behavior indicate?

   a. denial
   b. isolation
   c. anger
   d. depression

7. To help Mr. Krab move out of this stage, you can:

   a. visit him frequently before he calls you
   b. be firm — tell him that he does not need to behave like that
   c. explain to him that his behavior is upsetting the other patients
   d. take away his call light and close his door

8. Identify the five stages of death in the order that they occur.

   1. anger
   2. acceptance
   3. contentment
   4. bargaining
   5. isolation
   6. denial
   7. resentment
   8. depression

   a. 5, 4, 7, 8, 2
   b. 1, 6, 4, 7, 3
   c. 6, 1, 4, 8, 2
   d. 6, 7, 5, 4, 2

9. When you care for a patient who is dying, you should:

   a. keep his room darkened and quiet
   b. perform minimal custodial care only so as not to disturb him
   c. provide for all his physical needs
   d. all of the above

POST TEST - concluded

10. Your patient has intestinal cancer. He is unconscious and is frequently incontinent of stool. You understand that the incontinence is:

    a. a sign of approaching death
    b. probably due to his cancer
    c. unusual since most patients close to death become constipated and impacted
    d. only a temporary condition since patients with intestinal cancer usually do not have any stools at all

11. You notice that your terminal patient's breathing pattern has been alternating between very rapid and deep respirations which then suddenly stop for a few minutes. This type of respiration is known as:

    a. Chamber-Stroke respirations
    b. Cheyne-Stokes respirations
    c. Braxton-Hicks respirations
    d. Chime-Stricker respirations

12. You have a terminal cancer patient who is comatose. When taking vital signs, you find that this patient has a temperature of 96.4° F. She is very diaphoretic. You:

    a. record the temperature immediately
    b. know that this is a sign of approaching death
    c. understand that a decreased temperature is not unusual for terminal cancer patients
    d. recheck the temperature with another thermometer since patients who are approaching death usually have an elevated temperature

13. You find your dying patient staring into space with a fixed expression. You would:

    a. close the eyes
    b. cover the eyes with a damp washcloth
    c. check the pupils to see if they react to light
    d. keep the eyes moist with eye drops

14. Your patient has just died. While you are giving postmortem care, the nurse in charge tells you to discontinue all treatments. You understand that this means:

    a. you should remove the Foley catheter
    b. you should not change the dressing
    c. that cleaning the patient is unnecessary

15. When giving postmortem care, you remember to:

    a. roll the bed flat and place two pillows under the head
    b. replace the dentures and close the mouth
    c. give the patient a complete bath
    d. all of the above

ANSWERS TO POST TEST

Module L

1. d
2. b
3. c
4. d
5. b
6. c
7. a
8. c
9. c
10. a
11. b
12. d
13. c
14. a
15. b

POST TEST

Module M

Directions: Given sample forms and a patient situation by your instructor, role play the following, according to the guidelines from Unit 8, Module M.

1. Admitting a patient
2. Discharging a patient
3. Transferring a patient

ANSWERS TO POST TEST

Module M

1. Refer to Guidelines for Admission in Module M1
2. Refer to Guidelines for Discharge in Module M2
3. Refer to Guidelines for Transfer in Module M3